No. 97-53-CFX

Title: Jane M. Roberts, Guardian for Wanda Y. Johnson, Petitioner
v.
Galen of Virginia, Inc., formerly dba Humana Hospital-University of Louisville, dba University of Louisville Hospital

Docketed:
July 8, 1997

Court: United States Court of Appeals for the Sixth Circuit

Entry	Date	Proceedings and Orders
	Jul 8 1997	Petition for writ of certiorari filed. (Response due August 7, 1997)
	Aug 6 1997	Brief of respondent Galen of Virginia, Inc. in opposition filed.
	Aug 20 1997	DISTRIBUTED. September 29, 1997
	Oct 6 1997	REDISTRIBUTED. October 10, 1997
	Oct 14 1997	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
	May 13 1998	Brief amicus curiae of United States filed.
	May 19 1998	REDISTRIBUTED. June 4, 1998
	Jun 8 1998	Petition GRANTED. limited to Question 1 presented by the petition. SET FOR ARGUMENT December 1, 1998. **********
	Jul 20 1998	Record filed.
	Jul 23 1998	Joint appendix filed.
	Jul 23 1998	Brief of petitioner Galen of Virginia, Inc. filed.
	Jul 23 1998	Brief amici curiae of NOW Legal Defense and Education Fund, et al. filed.
	Jul 23 1998	LODGING consisitng of ten copies of "Hospital Violations of Emergency Medical Treatment and Labor Act"submitted by counsel for amici NOW, et al.
	Jul 23 1998	Brief amicus curiae of United States filed.
	Aug 17 1998	Order extending time to file brief of respondent on the merits until September 22, 1998.
	Sep 22 1998	Brief of respondents Galen of Virginia, et al. filed.
	Sep 22 1998	Brief amici curiae of American Hospital Association, et al. filed.
	Oct 7 1998	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Oct 20 1998	Reply brief of petitioner filed.
	Nov 2 1998	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Nov 6 1998	CIRCULATED.
	Dec 1 1998	ARGUED.

1pp

CORRECTED COPY

Supreme Court, U.S.
FILED

97 • 53 JUL 8 1997

OFFICE OF THE CLERK

(1)

No. _____

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1997

JANE M. ROBERTS, Guardian for WANDA Y. JOHNSON — **Petitioner**

versus

GALEN OF VIRGINIA, INC., formerly d/b/a HUMANA HOSPITAL-UNIVERSITY OF LOUISVILLE, d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — **Respondent**

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

JOSEPH H. MATTINGLY III
Counsel of Record for Petitioner
102 West Main Street
P.O. Box 678
Lebanon, Kentucky 40033
(502) 692 - 1718

89 pp

QUESTIONS PRESENTED

1. Whether a claim under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd requires proof of an improper motive on the part of the hospital, its staff or physicians as a pre-requisite for recovery?

2. Whether, if proof of an improper motive is a pre-requisite for recovery under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, proof of improper motive on the part of hospital administration and social services staff involved in a patient's treatment and discharge is sufficient without additional proof that independent contractor treating physician who executed a patient's discharge order was also improperly motivated?

3. Whether, under Kentucky law, surgical residents not employed directly by a hospital, are the hospital's ostensible agents whose negligence can be attributed to the hospital?

LIST OF PARTIES

The caption of the case in this Court contains the names of all parties to the proceedings in the United States Court of Appeals for the Sixth Circuit.

TABLE OF CONTENTS

Page

Questions Presented 1

List of Parties.....ii

Table of Authorities .....iv -v

Opinions Below 2

Jurisdiction 2

Statutes Involved 2

Statement of the Case 3-9

Reason for Granting the Writ 10-15

Certiorari Should Be Granted To Resolve Conflicts Among the Lower Courts in the Interpretation of a Federal Statute 10-15

Conclusion 16

Appendix A1-A65

TABLE OF AUTHORITIES

Cases: Page

Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990) 11

Correa v. Hospital San Franciso, 69 F.3d 1184 (1st Cir. 1995), *cert. denied*, ____ U.S. _____, 116 S. Ct. 1423, 134 L. Ed. 2d 547 (1996) 11, 13

Eberhardt v. City of Los Angeles, 62 F.3d 1253 (9th Cir. 1995) 11

Gatewood v. Washington Health Care Corp., 933 F.2d 1037 (D.C. Cir. 1991) 13

Holcomb v. Monahan, 30 F.3d 116 (11th Cir. 1994) 11

Power v. Arlington Hosp. Ass'n, 42 F.3d 851 (4th Cir. 1994) 10-13

Repp v. Anadarko Mun. Hosp., 43 F.3d 519 (10th Cir. 1994) 11

Roberts v. Galen of Virginia, Inc., 111 F.3d 405 (6th Cir. 1997) 2, 11

Summers v. Baptist Medical Ctr. Arkadelphia, 91 F.3d 1132 (8th Cir. 1996) 11, 13

Statutes:

28 U.S.C. § 1254(1) 2

42 U.S.C. § 1395dd 2-3, 10-13, 15

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1997

JANE M. ROBERTS, Guardian for WANDA Y. JOHNSON — **Petitioner**

versus

GALEN OF VIRGINIA, INC., formerly d/b/a HUMANA HOSPITAL-UNIVERSITY OF LOUISVILLE, d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — **Respondent**

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

The Petitioner, Jane M. Roberts, as Guardian for Wanda Y. Johnson, respectfully prays that a Writ of Certiorari issue to review the opinion and order of the United States Court of Appeals for the Sixth Circuit, entered on April 9, 1997.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit, whose judgment is herein sought to be reviewed, is reported at 111 F.3d. 405 (6th Cir. 1997) and is reprinted in the appendix hereto, pp. A1-A25. The two prior opinions of the United States District Court for the Western District of Kentucky in this case were not recommended for full-text publication but are reprinted in the appendix hereto, pp. A26-A45 and pp. A48-A52, respectively.

JURISDICTION

An order of the United States Court of Appeals for the Sixth Circuit was entered on April 9, 1997 affirming the order of the United States District Court for the Western District of Kentucky which granted summary judgment in favor of the respondent. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The statute involved in this case is the "Emergency Medical Treatment and Active Labor Act," 42 U.S.C. § 1395dd, reprinted in the appendix hereto, pp. A55-A65.

STATEMENT OF THE CASE

This action was filed in the United States District Court for the Western District of Kentucky on August 30, 1993 alleging, *inter alia*, that the Respondent, Galen of Virginia, Inc., formerly d/b/a Humana Hospital-University of Louisville, d/b/a University of Louisville Hospital (hereinafter "Humana") had violated the terms of 42 U.S.C. § 1395dd, The Emergency Medical Treatment and Active Labor Act (hereinafter "EMTALA") by transferring the Petitioner, Wanda Y. Johnson (hereinafter "Johnson"), to a nursing home in Indianapolis, Indiana before Humana had stabilized Johnson's condition. Johnson, a 36 year old mother of one child, was run over by a truck while walking home from her job as a cashier for Hardees Restaurant in Bardstown, Kentucky, late on the evening of May 19, 1992. She was flown from Bardstown to Humana where she was diagnosed with a left pelvic fracture, right fibular head fracture, T-4 and L3-L5 fractures and a closed head injury. Johnson underwent exploratory surgery upon admission to Humana during which her spleen was removed. She was placed on a mechanical ventilator and tracheostomy. During her hospitalization, she developed multiple pneumonias and diffuse gastritis. Her hospital course was further complicated by fever and sepsis with an elevated temperature to 108 degrees, the origin of which was never accurately determined. Following the temperature spike, Johnson's neurologic status deteriorated to a state of flaccid quadriparesis. Despite Humana's treatment,

Johnson's temperature spikes could not be controlled and episodes of pneumonia and urinary tract infection continued through the last week of her hospitalization.

In early July, 1992, Johnson's physician requested that the social services department at Humana begin making contacts with rehabilitation facilities and nursing homes to explore potential placement for Johnson if and when her condition was stabilized and she was ready to leave an acute care setting.

Humana's social workers immediately experienced difficulty in their efforts to find potential placement facilities for Johnson. The social workers learned that Johnson's husband had abandoned Johnson and their five year old son and had begun cohabitation with another woman in Springfield, Kentucky. No other close family member existed to provide assistance to the Humana social workers in developing a discharge plan for Johnson. Jane Roberts, Johnson's aunt, occasionally visited the hospital and attempted to locate Johnson's husband for the social workers. However, Roberts had not been appointed as Johnson's guardian at that time and did not have the legal authority, nor had she been requested, to act as Johnson's surrogate decision maker.

Another significant complication in locating a facility which would accept Johnson was her inability to pay. By mid-July, 1992, it became evident that Johnson's application for Kentucky Medicaid benefits would not be approved. Johnson had no private health insurance and obviously did not

have the resources to compensate any facility for her care. Johnson's medical expenses at Humana had already approached $400,000.00 and it was obvious to Humana that it would never be compensated for those charges.

In the midst of Humana's placement dilemma, Joanna Nolte, a marketer for Hometown Living Centers ("Hometown") in Indianapolis, Indiana, visited Louisville in an effort to initiate a relationship with the Humana hospitals whereby Humana would place its patients in Hometown's Indianapolis nursing homes.

On the evening of July 22, 1992, Nolte met with members of Humana's Social Services Department. Among those who attended Nolte's presentation was Nancy Fred, who had taken charge of Johnson's discharge plan. At the conclusion of Nolte's presentation, she was approached by Nancy Fred. At that time, Fred requested that Nolte look at Johnson and consider accepting Johnson in one of the Hometown facilities. According to Nolte, Fred appeared to be in a real placement dilemma with Johnson. Nolte testified that Fred advised her that she was receiving pressure from the administration at Humana to find a placement for Johnson because of Johnson's inability to pay for her care. Nolte explained to Fred that Johnson's level of acuity exceeded Nolte's ability to grant approval and indicated that she would have to refer Fred's request to the Administrator and Director of Nursing at Mayfair Manor for evaluation.

All the while, Johnson's medical condition continued to be volatile. On July 23, 1992, her temperature spiked to

101 degrees. A sputum culture revealed positive cocci and her doctor suspected that she had yet another episode of urinary tract infection. On the evening of July 23, 1992, Johnson's right lung collapsed and treatment was required every two hours. On July 24, 1992, the date of Johnson's discharge, her white blood count was over twice the normal level, her temperature had been rising for two days, and the nurses noticed cloudy urine, thick yellow sputum and an elevated heart rate. Karen Martin, the nurse on duty during Johnson's last day of hospitalization at Humana, testified that all of these symptoms indicated the presence of infection.

Meanwhile, Mayfair Manor declined Humana's referral of Johnson because her care required too many skilled nursing hours. Yet, somehow another Hometown facility, Crestview Nursing Home ("Crestview"), which had even fewer skilled nurses than Mayfair, picked up the Johnson referral and agreed to accept her. The first notation that Crestview had even been considered by the social workers at Humana appears in a social services note on July 24, 1992, wherein Nancy Fred indicated that Johnson would be transferred to Crestview on that date at 2:30 p.m.

In its haste to expedite Johnson's transfer to Crestview, Humana ignored its standard procedures and protocols for discharge and transfer. No authorization for the transfer was obtained from Johnson's husband or mother. Nancy Fred simply called Jane Roberts, Johnson's aunt and occasional visitor, and *told her* that Johnson would be transferred to Crestview Nursing Home in Indianapolis that

afternoon. Fred gave Roberts Crestview's telephone number. She did not ask Roberts to check with Johnson's family to determine whether they would like to visit the facility before the transfer was arranged or whether they would even approve of a transfer which would place Johnson some three hours driving distance from their home. Fred gave Roberts no information about Crestview or about any benefits it could provide to Johnson. In fact, neither Fred nor anyone else at Humana could then provide any such information because no one knew much about Crestview.

In addition to Humana's violation of its own discharge policy and protocols which mandate advising the patient or her family of discharge plans in order to provide the patient or family at least an opportunity to decline the discharge and make other arrangements, Humana also violated its policy and protocol by failing to gain approval for the transfer from the accepting physician at Crestview. The physicians for Crestview were unaware of Johnson's transfer until she had already arrived.

There can be little question that Crestview was not an appropriate placement for Johnson. Even the Crestview physicians testified that its facility was inappropriate.

Johnson's condition deteriorated significantly as a result of her transfer from Humana. The nurses at Crestview were so alarmed by Johnson's condition upon her arrival in Indianapolis that they thought she was going to die. Within hours of her arrival at Crestview, Johnson's temperature had spiked to 105 degrees and she was rushed to Midwest

Medical Center where she remained hospitalized for almost six months. Dr. John W. Stuy was Johnson's principal treating physician during her hospitalization in Indianapolis and he testified that the complications experienced by Johnson and which caused her deterioration were present while she was hospitalized in Louisville but were exacerbated because she was transferred from Humana to a facility which was unable to properly care for her. Dr. Stuy testified that the antibiotic that was prescribed for Johnson when she left Humana was not sensitive to the cultures which were grown at Midwest Medical Center and was not treating her infection. He commented that if she had remained on the antibiotic much longer, she may have died. Dr. Stuy testified that Johnson should never have been transferred from Humana.

As a final insult, Humana's transfer of Johnson to Indianapolis placed her in a jurisdiction where she was ineligible for public medical assistance. Had she remained hospitalized at Humana, Johnson would never have incurred personal liability for the payment of medical expenses because of Humana's receipt of millions of dollars from Kentucky governmental entities to provide care to indigent patients. However, once Johnson was transferred from Humana to Indianapolis she was no longer entitled to that benefit. In fact, Johnson's application for Medicaid benefits in Indiana was denied because she was not a resident of Indiana. As a direct result of Humana's unilateral decision to ship Johnson to Indiana, Johnson incurred medical expenses of over $300,000.00 for which she is now personally

obligated.

Although the District Court had initially determined that genuine issues of material fact existed which precluded Summary Judgment in favor of Humana on the EMTALA claim, upon reconsideration it determined that proof of improper motive was a prerequisite for recovery under EMTALA. It then found that even though Johnson had presented proof that could indicate that Humana's staff and administration was improperly motivated in arranging Johnson's transfer, because Johnson had not provided proof that the independent contractor physicians who signed the order to discharge her had also been improperly motivated, no genuine issue of material fact existed as to "causation" and therefore granted Humana Summary Judgment on Johnson's EMTALA claim and dismissed her case.

On appeal, Johnson argued that every other Circuit Court of Appeals in the country which had considered the issue had expressly rejected the notion that proof of improper motive was required to establish a claim under EMTALA. However, in a two to one decision, the Court of Appeals for the Sixth Circuit split with the interpretation of EMTALA by the other Circuit Courts of Appeals and held that EMTALA required proof of improper motive. It further held that proof of improper motive by hospital administration is insufficient and required proof that the discharging physician was improperly motivated for a claimant to succeed under EMTALA.

REASON FOR GRANTING THE WRIT

Certiorari Should Be Granted To Resolve Conflicts Among the Lower Courts in the Interpretation of a Federal Statute.

The principal issue in this case is whether a claim under EMTALA requires proof of an improper motive on the part of the hospital, its staff or physicians as a prerequisite for recovery. The issue is a substantial one to every potential claimant under EMTALA. In fact, if a claimant must prove the inner thoughts and prejudices of attending hospital personnel in order to recover under EMTALA, the successful pursuit of a civil EMTALA claim is virtually impossible.

If certiorari were granted, this would be the first case before this Court interpreting the prerequisites to recovery under EMTALA. This Court could then provide direction to the lower courts in an area where there has developed a clear split in interpretation of the relevant federal statute.

The various Circuit Courts of Appeals have struggled to interpret EMTALA as providing a substantial federal remedy while attempting to provide some limits on the application of the statute so that EMTALA is not utilized as a federal medical malpractice statute. The Circuit Courts of Appeals have uniformly held that, "EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence." *Power v.*

Arlington Hosp. Ass'n, 42 F.3d 851, 856 (4th Cir. 1994). *See also Roberts v. Galen of Virginia, Inc.*, 111 F.3d 405 (6th Cir. 1997); *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996); *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), *cert. denied*, ___ U.S. _____, 116 S. Ct. 1423, 134 L.Ed.2d 547 (1996); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994).

The Courts have labored to define exactly what a claimant must prove if the statute does not create a federal remedy for medical malpractice. The Court of Appeals for the Sixth Circuit determined that the way to limit the potentially sweeping scope of the statute's language is to require that a claimant prove improper motive in order to recover under EMTALA. *Roberts v. Galen of Virginia, Inc., supra.*; *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990). While the Sixth Circuit's interpretation clearly prevents EMTALA from being utilized as a substitute for a state law malpractice action, in the opinion of the Fourth Circuit such an interpretation also makes proving a civil EMTALA claim virtually impossible. *Power v. Arlington Hosp. Ass'n, supra.* The Fourth Circuit explained its rejection of the Sixth Circuit's reasoning as follows:

> First, there is nothing in the statute itself that requires indigence, inability to pay or any other improper motive on the part of a hospital as a prerequisite to recovery. The language of § 1395dd(a) simply refers to "any individual" who presents to the emergency room. Second, it seems to us that the expanse of motives suggested by the Sixth Circuit . . . is so broad as to be no limit at all, and as a practical matter amounts to not having a motive requirement. Anyone who alleges that she did not receive an appropriate medical screening examination can simply find an improper motive that fits, whether it is sex, nationality, income, or occupation, and simply allege it. Which leads, thirdly, to the most fundamental problem with the motive requirement: the proof predicament. We agree . . . that having to prove the existence of an improper motive on the part of a hospital, its employees or its physicians, would make a civil EMTALA claim virtually impossible. We do not believe that proving the inner thoughts and prejudices of attending hospital personnel is required in order to recover under EMTALA.

Power v. Arlington Hosp. Ass'n, 42 F.3d, at 857-858.

Based on this or similar reasoning, the Courts of Appeal for the District of Columbia Circuit, the First Circuit, the Fourth Circuit and the Eighth Circuit expressly disagree that proof of an improper motive is a prerequisite to recovery under EMTALA. *Gatewood v. Washington Health Care Corp.*, 933 F.2d 1037 (D.C. Cir. 1991); *Correa v. Hospital San Francisco, supra.*; *Power v. Arlington Hosp. Ass'n, supra.*; *Summers v. Baptist Medical Ctr. Arkadelphia, supra.* Rather than adopting the limitation espoused by the Sixth Circuit, each of the other Circuit Courts of Appeal have determined that the proof required of a claimant in order to succeed under EMTALA consists of evidence to show that the claimant was not treated as other similarly situated patients are treated, within the hospital's capabilities. According to each of the Circuit Courts of Appeal that have considered the issue, other than the Sixth, it is up to the hospital itself to establish its own policies and procedures. Having done so, the Hospital must apply them alike to all patients.

The significance to a claimant of a uniform interpretation of the prerequisites to recovery under EMTALA could not be more clearly evident than it is with the facts of the case at bar. Both the District Court and the Court of Appeals in this case held that a genuine issue of fact existed as to whether or not Humana had stabilized Johnson's emergency medical condition prior to her discharge and transfer. Furthermore, Johnson was able to produce substantial evidence that she was not treated as other similarly

situated patients are treated at Humana. Specifically, Johnson produced Humana's own policies and procedures which require that when a patient is transferred from the hospital's critical care complex to another facility, Humana's social services staff obtain approval for the transfer from the patient's family and further require the attending physician at Humana to obtain the prior approval of the physician at the receiving facility before discharging and transferring a patient.

These requirements were not simply ministerial in nature but went to the very heart of the discharge and transfer procedure at Humana. In fact, Johnson's most fundamental argument in this case is that had *anyone* acting with Johnson's best interest at heart been given an opportunity to investigate Crestview as a potential placement they would have readily recognized that Crestview could not handle Johnson's care, would have refused transfer to Crestview and would have insisted that other options be pursued. It makes sense that after a transfer decision has been made for a patient coming out of the critical care complex one of the most important functions of the physician is the arrangement of physician acceptance of the patient at the receiving facility. It is certainly probable that patient's coming from a critical care complex have special needs which require one-to-one consultation between the physician arranging the transfer and the physician accepting the patient at the receiving facility. Where, as in Johnson's case, the transferring physician knows nothing about the receiving facility, one-to-one consultation with the physician at the receiving facility is

imperative so that the transferring physician can determine that the receiving facility is capable of handling the patient's care needs. Had Humana physicians or social workers simply followed their own policies and procedures, this whole litigation would have been avoided. The litigation would have been avoided because the physicians responsible for accepting patients at Crestview would have declined acceptance of Johnson.

This proof of disparate treatment is sufficient in every Circuit in the United States, other than the Sixth, to get an EMTALA claim to a jury. However, in the Sixth Circuit no matter how compelling the other evidence, if the discharging physician cannot be implicated with a showing of improper motive in the execution of his or her discharge of a patient, a claim under EMTALA will fail.

The prerequisites for recovery under EMTALA should be uniform throughout the United States. Claimants in the Sixth Circuit should not be required to prove more, and cannot expect that they can prove less, than claimants in other areas of the country. Potential claimants in Circuits which have not directly addressed the issue should not be left to guess whether their Circuit will adopt the interpretation of the Sixth Circuit or the interpretation of the other Circuits. This clear divergence in the interpretation of this important federal statute among the Circuit Courts of Appeal is a compelling reason for this Court to issue a Writ of Certiorari in this case.

CONCLUSION

For the foregoing reasons, this Petition for Certiorari should be granted and consider those issues identified herein.

Respectfully submitted on
July 3, 1997,
JOSEPH H. MATTINGLY III
Counsel of Record for the Petitioner

JOSEPH H. MATTINGLY III, P.S.C.
102 West Main Street
P.O. Box 678
Lebanon, Kentucky 40033
(502) 692 - 1718

APPENDIX

No. 96-5298

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JANE ROBERTS, as Guardian for
Wanda Y. Johnson,
Plaintiff-Appellant,

v.

GALEN OF VIRGINIA, INC.,
formerly d/b/a Humana Hospital-
University of Louisville, d/b/a
University of Louisville Hospital,
Defendant-Appellee.

Decided and Filed April 9, 1997

Before: KENNEDY, NELSON, and VAN GRAAFEILAND, Circuit Judge.

---

* The Honorable Ellsworth A. Van Graafeiland, Circuit Judge of the United States Court of Appeals for the Second Circuit, sitting by designation.

KENNEDY, J., delivered the opinion of the court, in which VAN GRAAFEILAND, J., joined. NELSON, J. (pp. 18-89), delivered a separate opinion concurring in part and dissenting in part.

KENNEDY, Circuit Judge. Plaintiff, Jane Roberts, appeals the District Court's order granting summary judgment for the defendant in this action under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (Supp. 1996). Plaintiff alleges that her critically-ill niece, Wanda Johnson, was transferred from the defendant hospital to a nursing care facility in an unstable condition in violation of the Emergency Medical Treatment and Active Labor Act. For the reasons set forth below, we **AFFIRM** the judgment of the District Court.

I.

Wanda Johnson was hospitalized at Humana Hospital-University of Louisville ("Humana") on May 19, 1992 after sustaining massive severe injuries caused by a collision with a truck. A few weeks before July 22, 1992, the surgical resident treating Johnson requested a Humana social worker to search for a long term care facility for Johnson. While the social worker, Nancy Fred, was aware Johnson had no insurance, the resident who authorized her discharge had no such knowledge. On July 22, 1992, after two nursing homes turned Johnson down following on-site evaluations of her condition by their directors of nursing, a representative of Crestview Health Care Facility in the State of Indiana agreed

to take Johnson. She was transferred to Crestview on July 24, 1992.

The day after Johnson's arrival at Crestview, Johnson's condition deteriorated significantly. She was taken to Midwest Medical Center, also in Indiana, where she remained for many months incurring $388,679.93 in medical bills. The State of Indiana rejected Johnson's application for medical assistance under the Indiana Medicaid Program because she failed to meet the Indiana residency requirements.

On August 30, 1993, plaintiff, as guardian for Wanda Johnson, filed this action under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (Supp. 1996), alleging that Humana failed to comply with EMTALA in the transfer of Johnson to a skilled nursing facility. Plaintiff also alleged in her complaint that Humana violated the Due Process and Equal Protection Clauses of the United States and Kentucky Constitutions and that Humana should be liable for negligence under state law for the acts of the medical residents responsible for Johnson's care. Humana filed a motion for summary judgment on all of plaintiff's claims.

The District Court initially denied Humana's motion for summary judgment on the EMTALA claim because it found there was a genuine issue of material fact as to whether Johnson was stabilized before she was transferred to Crestview and because there was a genuine issue of material

fact as to whether Humana acted with an improper motive. The District Court granted Humana's motion on the remaining claims. Regarding the state law negligence claim, the District Court held that the hospital could not be liable for the actions of its residents because the residents were not ostensible agents of the hospital. Humana moved for reconsideration of the EMTALA claim. On reconsideration, the District Court held that, despite the existence of genuine issues of material fact as to stabilization and improper motive, plaintiff failed to prove that "either the medical opinion that Johnson was stable or the decision to authorize her transfer was caused by an improper motive." Thus, on reconsideration, the District Court granted Humana's motion for summary judgment on the EMTALA claim. Plaintiff appeals solely from the disposition of the EMTALA claim and the District Court's conclusion that the residents were not ostensible agents of the hospital.

II.

This Court's review of a grant of summary judgment is *de novo*; we use the same test used by the District Court. *See Brooks v. American Broadcasting Cos.*, 932 F.2d 495, 500 (6th Cir. 1991). In reviewing summary judgment motions, courts must view the evidence in the light most favorable to the nonmoving party to determine whether a genuine issue of material fact exists. *See Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970). Under Fed. R. Civ. P. 56(c), summary judgment is proper if the evidence

"'show[s] that there is no genuine issue as to any material fact and that the moving party is entitled to [a] judgment as a matter of law.'" *Canderm Pharmacal, Ltd. V. Elder Pharmaceuticals, Inc.*, 862 F.2d 597, 601 (6th Cir. 1988) (quoting Fed. R. Civ. P. 56(c)).

III.

A.

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, in pertinent part, provides:

> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--
>
> (A) within the staff and facilities available at the hospital. for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical

> facility in accordance with subsection (c) of this section.

42 U.S.C. § 1395dd(b)(1). As defined by the EMTALA, "to stabilize" under subsection (b)(1)(A) means, "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . " 42 U.S.C. § 1395dd(e)(3)(A). As explained by our Court in *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990):

> the impetus to this legislation came from highly publicized incidents where hospital emergency rooms[1] allegedly, based only on a patient's financial inadequacy, failed to provide a medical screening that would have been provided a paying patient, or transferred or discharged a patient without taking steps that would have been taken for a paying patient.

[1]As concluded by our Court in *Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990), EMTALA's application is not limited to a patient's treatment and discharge from an emergency room. Rather, "once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room." *Id.* at 1134.

Id. at 268. Although the legislative history suggests otherwise, the EMTALA applies to all patients regardless of their financial status. *Id.*

The dispute in this case arises out of the District Court's conclusion that our Court's decision in *Cleland* requires that plaintiff prove the hospital acted with an improper motive in order to recover under EMTALA. Specifically, the District Court concluded and the defendant contends that merely transferring a patient before the patient is sufficiently stabilized does not constitute a violation of EMTALA; rather, plaintiff must prove that the hospital acted with an improper motive when it failed to stabilize the patient before transfer. In *Cleland*, parents of a fifteen-year-old boy took their soon to an emergency room complaining of cramps and vomiting. A doctor at the hospital examined the boy, diagnosed influenza, and discharged the patient four hours later. *Id.* at 268. Less than twenty-four hours after he was discharged, the boy died of cardiac arrest caused by intussusception.[2] The district court dismissed the parents' cause of action under EMTALA because the court concluded that the EMTALA applied only to indigent patients. This Court affirmed the dismissal of the complaint, but on different grounds. *Id.*

In analyzing whether the Clelands' claim was properly dismissed, this Court first noted that the parents did not allege

[2]The slipping of one part of an intestine into another part just below it. TABER'S CYCLOPEDIC MEDICAL DICTIONARY I-35 (9th ed. 1963).

that the care provided to their son was deficient or that the hospital's actions in connection with their son's screening and stabilization was in any way different than the care that would have been offered to any other patient. *Id.* at 269. Our Court then sought to define the terms "appropriate medical screening" and "emergency medical condition" which appear in subsection (a) of EMTALA in order to determine whether the Clelands' claim could survive despite their admission that their son's treatment was not disparate or insufficient but simply wrong. Subsection (a) of EMTALA states:

> In the case of a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an *appropriate medical screening examination* within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an *emergency medical condition* . . . exists.

42 U.S.C. § 1395dd(a)(emphasis added). The court refused to interpret the term "appropriate" as referring to a malpractice or other standard of care. Instead, we concluded

that the term "appropriate" refers "to the motives with which the hospital acts." *Cleland*, 917 F.2d at 272. The court further explained, "If it acts in the same manner as it would have for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute." *Id.*

Addressing the concern that this approach might "constitute a backdoor means of limiting coverage to the indigent or uninsured," this Court commented:

> . . . A hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason (including, without limitation, race, sex, politics, occupation, education, personal prejudice, drunkenness, spite, etc.) may be liable under this section. Similarly, a discharge that to the knowledge of those conducting it left a patient with an "emergency medical condition" in an "unstable" condition would be actionable.
>
> We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the

> medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition. If a hospital refused treatment to a person for any of these reasons, or gave cursory treatment . . . the patient would fall squarely within the statutory language.

Id. Because the parents did not allege that their son was treated differently than any other patient, we affirmed the district court's dismissal of their claim. *Id.*

The District Court in the instant case properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA. As noted by the United States Court of Appeals for the Fourth Circuit, "EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence." *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994). *See also Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996); *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), *cert. denied*, 116 S. Ct. 1423 (1996); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994). To distinguish

an EMTALA claim from a state law claim for negligence, a plaintiff must establish something more than a hospital's breach of the applicable standard of care. We reject the position espoused by plaintiff that, to succeed on a claim under the EMTALA, she can prove that Humana's treatment of Johnson was not uniform to patients suffering from the same medical condition as Johnson. Proof of disparate treatment, in plaintiff's view, distinguishes an EMTALA claim from a state law negligence claim. If we were to adopt this position, however, we would effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable standard of care with respect to all similarly situated patients. In other words, we would require a hospital to prove that it has committed medical negligence or malpractice. In order to prevent placing hospitals in such a precarious position, we declined in *Cleland* to adopt such an approach. Instead, *Cleland* imposed upon the plaintiff a burden to bring forth some showing of improper motivation. As explained in *Cleland*, a plaintiff is not limited to a showing of improper motivation involving indigency or lack or insurance. Rather, other improper reasons include race, sex, politics, occupation, education, personal prejudice, drunkenness, or spite; that is, anything except medical negligence. *Cleland* requires proof of the existence of any improper motivation such as those listed above to make a case of inappropriate screening or

improper discharge.[3] To interpret *Cleland* in any other manner would effectively reduce the EMTALA to nothing more than a federal remedy for medical malpractice.[4]

B.

With these requirements in mind, we turn to the question of whether Ms. Johnson was stabilized before she was transferred to Crestview. *Cleland* guides us in analyzing

---

[3]*Cleland* defined the term "appropriate medical screening" and in doing so inserted examples of improper motives. Notably, the term "appropriate medical screening" appears in subsection (a) of EMTALA not subsection (b), the subsection at issue in this case. However, *Cleland* specifically noted, after setting forth examples of improper motive, that "[s]imilarly, a discharge that to the knowledge of those conducting it left a patent with an 'emergency medical condition' in an 'unstable' condition would be actionable." *Cleland* at 272. Moreover, we see no rational reason to set forth differing standards when applying subsection (a) and (b).

[4]We, therefore, reject the approach of the Fourth Circuit taken in *In the Matter of Baby "K"*, 16 F.3d 590 (4th Cir. 1994). In *In the Matter of Baby "K"*, a hospital sought a declaratory judgment that it was not required under the EMTALA to provide respiratory support for a baby with anencephaly when presented to the hospital in respiratory distress. *Id.* at 592. The hospital contended that because aggressive treatment, such as respiratory support, would not serve any purpose, it was obligated only to provide the supportive care of nutrition, hydration, and warmth. *Id.* The hospital argued that the EMTALA required it only to provide the baby the same care it would provide to other babies suffering from anencephaly -- nutrition, hydration, and warmth. The court disagreed.

In the court's opinion, the statutory language of EMTALA is clear and it does not "allow the Hospital to fulfill its duty to provide stabilizing treatment by simply dispensing uniform treatment. Rather, the Hospital must provide that treatment necessary to prevent the material deterioration of each patient's emergency medical condition." *Id.* at 596. The court thus concluded that the hospital's uniform treatment of providing warmth, nutrition, and hydration was insufficient to avoid liability under EMTALA. Rather, the hospital was obligated to provide the treatment necessary to prevent the material deterioration of Baby K's condition which included respiratory support. *Id.*

a stabilization case. As with appropriate medical screening, the doctors are not charged with the duty under EMTALA of proper diagnosis; rather, they are charged with the duty of stabilizing a patient's condition as it as known to them. *Cleland*, 917 F.2d at 271. As noted by the District Court, there is a genuine issue of material fact as to this question. The day before Johnson was transferred, Johnson developed the symptoms of a urinary tract infection which were known to and treated by her physicians, but Johnson was transferred before doctors at Humana could determine whether the infection would respond to the antibiotic prescribed.

Drs. Richardson, Harbrecht, and Abou-Jaoude, the physicians involved in Johnson's care, attested that Johnson's condition was sufficiently stable to warrant discharge. Lynette Ferguson, Crestview's Director of Nursing, assessed Johnson's condition approximately two hours after her arrival. In her opinion, Johnson's condition was sufficiently stable to be treated at Crestview. Dr. Taiser Shatara, Johnson's admitting physician to Crestview, testified that, based on the information he had learned from the nurses at Humana, he believed that Johnson was an appropriate candidate for nursing home placement and stable when transferred. However, he testified that, had he known of the full history of Johnson's hospitalization, her suspected urinary tract infection, and elevated white count, he would not have accepted her as a patient at Crestview. Dr. John Stuy testified that, in his opinion, Johnson should have remained at Humana

until her doctors could review the results of the culture and determine whether the prescribed antibiotic would have successfully treated the infection.

In addition to this conflicting testimony, there is a dispute as to whether Johnson's condition was stabilized upon transfer but worsened by Crestview's insufficient treatment of Johnson. Most significantly, contrary to instructions given by Humana, Crestview staff did not suction Johnson's lungs nearly as often as recommended.

Humana has not appealed the District Court's holding that there is a genuine issue of material fact regarding whether Johnson was stabilized when she was discharged from Humana.

C.

Our analysis, however, does not cease with the conclusion that there exists a genuine of material fact regarding whether Johnson was stabilized when she was discharged from Humana. We must additionally determine, pursuant to *Cleland*, whether Humana acted with an improper motive when it discharged Johnson.

Joanna Nolte, a representative of Crestview Health Care Facility, testified that Nancy Fred explained to her "they had been trying to discharge and without any avail to other facilities and that she was getting a lot of pressure to discharge this person due to they knew they weren't going to get paid for this person." Nolte testified that Fred did not specifically mention who was placing pressure on her to

discharge Wanda, she said "she was just receiving pressure from the hospital that, you know, that we needed -- that she needed to find placement for this person." As acknowledged by the District Court, this statement suggests that some representative of the hospital may have been acting with an improper motive. However, as the District Court also concluded, there is no evidence that this improper motive caused Dr. Abou-Jaoude to issue Johnson's discharge order. Fred played no role in diagnosing Johnson as stabilized at the time of discharge. Even assuming financial considerations influenced Ms. Fred when pursuing a placement for Johnson, plaintiff has brought forth nothing more than speculation in support of her theory that the discharge papers were signed before Johnson was stabilized due to inappropriate economic considerations.

In support of its motion for summary judgment, defendant submitted the affidavits of Dr. David Richardson, Dr. Brian Harbrecht, and Dr. Abou-Jaoude. Dr. Richardson attested that he participated in Johnson's care and was certain that her financial condition was not a consideration in the medical decision to discharge her. Dr. Harbrecht attested that he consulted in and approved of Johnson's discharge and that her financial status played no role. Dr. Abou-Jaoude similarly attested that he was unaware of Johnson's financial status when he wrote the discharge order and that her financial status was not a factor in his decision to write the order. Moreover, Frank M. Miller, Chief of the Surgical Intensive

Care Unit and Chief of the Department of Surgery at Humana, testified that the attending physicians and residents "never have any idea what the financial condition of the patient is." In response, plaintiff brought forth no evidence suggesting that Johnson's treating physicians were aware of Johnson's financial condition. Thus, plaintiff failed to create a genuine issue of material fact as to causation. Without some evidence of a causal relation between the hospital employee possessing the improper motive and the discharge of the unstable patient, a plaintiff can not establish that a patient's discharge was caused by an improper motive. Accordingly, the District Court properly granted defendant summary judgment on the plaintiff's claim under the EMTALA.

IV.

In addition to the EMTALA claim, plaintiff brought a state law negligence claim against Humana for the acts of the surgical residents who treated Johnson. In order to hold the hospital liable for the negligent acts of the surgical residents, plaintiff argued they were ostensible agents of the hospital. The District Court held that the surgical residents at Humana were not ostensible agents and, therefore, granted summary judgment on behalf of Humana on the state law claim.

As noted by the District Court, Kentucky courts have relied heavily on the manner in which the principal holds itself out of the public in determining whether an ostensible agent or apparent authority relationship exits. In *Williams v.*

St. Claire Medical Center, 657 S.W.2d 590 (Ky. Ct. App. 1983), the court relied on the following definitions of ostensible agency:

> Apparent authority is not actual authority, but rather "is that which, by reason of prevailing usage or other circumstance, the agent is in effect held out by the principal as possessing. It is a matter of appearances, fairly chargeable to the principal and by which persons dealt with are deceived, and on which they rely."

Id. at 595 (quoting *Estell v. Barrickman*, 571 S.W.2d 650, 652 (Ky. Ct. App. 1978)).

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Id. at 595-596 (quoting The Restatement (Second) of Agency § 267 (1958)). Because the hospital in *Williams* did nothing to inform the plaintiff that a nurse, an independent contractor whose actions were alleged to be negligent, was something

other than a hospital employee, the "hospital 'held-out' [the nurse] as an employee, thus creating an apparent agency." *Id.* at 596.

In *Paintsville Hospital Co. v. Rose*, 683 S.W.2d 255 (Ky. 1985), the Supreme Court of Kentucky specifically addressed the question of whether a hospital could be liable for the negligence of an emergency room physician who was not employed by the hospital. In a case where the hospital did nothing to alert the public that its emergency room physicians were not hospital employees, the court concluded that it is "unreasonable to put a duty on the patient to inquire of each person who treats him whether he is an employee or independent contractor of the hospital." *Id.* at 258 (citations omitted). The court further relied on the following statements from other courts on this issue in concluding that a hospital may be liable for the negligent acts of an independent emergency room physician:

> Absent notice to the contrary, therefore, plaintiff had the right to assume that the treatment received was being rendered through hospital employees and that any negligence associated with the treatment would render the hospital responsible. *Arthur v. St. Peters Hospital*, 169 N.J. Super. 575, 405 A.2d 443, 447 (1979).
>
> In our view, the critical question is whether

> the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. *Grewe v. Mt. Clemens General Hospital*, 404 Mich. 240, 273 N.W.2d 429, 433 (1978).

Id. at 258.

Lastly, in *Floyd v. Humana of Virginia*, 787 S.W.2d 267 (Ky. Ct. App. 1989), the Kentucky Court of Appeals addressed the ostensible agency issue in a case where the patient had signed a form indicating that doctors in the hospital were independent contractors. In light of this evidence, the court concluded:

> we find the testimony of the appellant admitting that she had read and signed each of the admission forms to Humana of Virginia Hospital, Inc. d/b/a Humana Hospital University, which indicates her knowledge that the doctors were independent contractors and not agents of the hospital, to be determinative in this case. There was no representation or other action to induce appellant to believe that the physicians were

> employees or agents of Humana Hospital University; in addition, the admission form which appellant signed specially indicated same. Accordingly, there can be no valid argument that the ostensible agency doctrine would make Humana of Virginia liable in this case.

Id. at 270 (citing *Williams v. St. Claire Medical Center*, 657 S.W.2d 590 (Ky. Ct. App. 1983)).

In the case at hand, Humana's outpatient registration and authorization for medical treatment form states:

> INDEPENDENT STATUS OF
> PHYSICIANS, RESIDENTS AND
> MEDICAL STUDENTS.
>
> The medical treatment rendered to you during your hospital admission will be provided by physicians, residents and medical students (under the supervision of physicians and/or residents). These physicians, residents, and medical students are independent practitioners and are not employees or agents of the hospital.
>
> In addition, certain professional services rendered to you during your hospital

> admission will be provided by physicians, residents and medical students who are independent practitioners and are not employees or agents of Humana Hospital - University of Louisville. These services include but are not limited to the following: Radiology, Anesthesiology, Emergency Room, Pathology.
>
> The physicians providing treatment to you and the physicians providing the above mentioned professional services are not employees or agents of Humana Hospital - University of Louisville.

The record indicates that a form with this wording was specifically drafted for Johnson[5] on May 20, 1992 at 1:00 a.m., shortly after she arrived at the hospital. The form, however, was not signed by Johnson presumably because she was physically unable to do so. Thus, we are faced with a case where a hospital has overtly represented that its physicians are not its agents but where the patient has not seen or acknowledged the disclaimer. Whether or not Johnson read or signed the disclaimer is not dispositive. If it were dispositive, patients too critical to sign the consent form could sue residents for negligence whereas those able to read

---

[5]Neither the parties nor the record indicate why an outpatient, rather than an inpatient, form was drafted for Johnson.

and sign the form could not. As stressed by Kentucky case law, the result should, instead, turn on whether the hospital holds its physicians out to be employees or something else. The passages cited to approvingly by the Kentucky courts focus particularly on the actions of the hospital. As noted by *Williams v. St. Claire Medical Center*, 657 S.W.2d 590 (Ky. Ct. App. 1983), "apparent authority is not actual authority, but rather 'is that which, by reason of prevailing usage or other circumstance, the agent is in effect held out by the principal as possessing. It is a matter of appearances, fairly chargeable to the principal and by which persons dealt with are deceived, and on which they rely.'" *Id.* at 595 (quoting *Estell v. Barrickman*, 571 S.W.2d 650, 652 (Ky. Ct. App. 1978)). And, as defined by the Restatement,

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Id. at 595-596 (quoting The Restatement (Second) of Agency § 267 (1958)). Thus, under Kentucky law, the actions of the hospital, rather than the knowledge of the patient, is controlling in a case where the patient is unable to obtain

actual knowledge of the hospital's disclaimer. Here, Humana clearly attempted to alert the public that its physicians were not employees or agents of the hospital. The District Court, therefore, properly concluded that the surgical residents were not ostensible agents of the hospital. Accordingly, the dismissal of plaintiff's state law negligence is affirmed.

V.

For the foregoing reasons, the judgment of the District Court is **AFFIRMED**.

DAVID A. NELSON, Circuit Judge, concurring in part and dissenting in part. I agree with the court's disposition of Mrs. Johnson's negligence claim. As explained in Part IV of Judge Kennedy's opinion, the surgical residents could not properly be found to have been ostensible agents of defendant Humana - and absent an agency relationship, the residents' alleged negligence could not properly be imputed to Humana.

I disagree with the court's disposition of Mrs. Johnson's claim under the Emergency Medical Treatment and Active Labor Act. A covered hospital that is acting from an improper motive is prohibited by the Act from discharging a patient such as Mrs. Johnson for transfer to another facility without first having stabilized her medical condition. Stabilization has not been achieved if the transfer is likely to result in material deterioration of the patient's condition. Like my colleagues on the panel, I believe that there is a

genuine issue of fact as to whether Mrs. Johnson was stabilized at the time of her transfer from Humana to the Crestview facility. Unlike my colleagues, I believe that there is also a genuine issue of fact as to whether Humana acted from an improper motive. The issue is a material one, under our case law, so it seems to me that summary judgment ought not to have been granted on the statutory claim.

As far as the record discloses, to be sure, Dr. Abou-Jaoude -- the physician who issued Mrs. Johnson's discharge order -- was not knowingly influenced by improper financial considerations when he decided that it was appropriate for Mrs. Johnson to be discharged. But as Dr. Abou-Jaoude made clear in his deposition testimony, the discharge decision was not made in a vacuum. Mrs. Johnson was a "high-risk" patient who needed "skilled nursing care," Dr. Abou-Jaoude testified. He clearly would not have discharged her had he thought she was going to a boarding house, for example. The doctor talked to social worker Nancy Fred "multiple times" about Mrs. Johnson's discharge plan, and he engaged in "frequent discussions" with Ms. Fred about where Mrs. Johnson was going to go and who was going to take care of her. He specified placement in a skilled nursing care facility, according to his testimony, and he assumed that the social workers would locate a facility with nurses who could take care of the patient. As far as selection of a specific placement was concerned, Dr. Abou-Jaoude testified, "we just left it in the hands of the social workers. . . ."

The social workers' hands may not have been as clean as the doctor's apparently were. There is evidence from which a jury could infer that Ms. Fred was receiving pressure from Humana's administration to get Mrs. Johnson discharged, there being no prospect that Humana would ever be paid for taking care of this patient. There is evidence from which a jury could infer that the Crestview facility was not an appropriate placement for Mrs. Johnson. And given the extent to which Dr. Abou-Jaoude relied on Ms. Fred to locate a facility to which Mrs. Johnson could be transferred without any material deterioration in her condition, it seems to me that it would be permissible for a jury to find that rather than letting Mrs. Johnson stay put until an appropriate placement could be found elsewhere, Humana sent Mrs. Johnson to an inappropriate facility because Humana was not being paid. Such a finding would make Humana liable under the Act. Accordingly, I respectfully dissent from affirmance of the summary judgment for Humana on Mrs. Johnson's statutory claim.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — PLAINTIFF

v. — CIVIL ACTION NO. 3:93CV-544-S

GALEN OF VIRGINIA, INC., d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — DEFENDANT

MEMORANDUM OPINION

This matter is before the court on the motion of the defendant, Galen of Virginia, Inc., d/b/a University of Louisville Hospital (the "Hospital"), for partial summary judgment.

The complaint was filed in this court invoking our federal question jurisdiction. The plaintiff alleges (1) that the Hospital violated the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (§ 1395dd), (2) that the Hospital violated Wanda Y. Johnson's right to due process and equal protection of the law under the Constitutions of the United States and Kentucky, and (3) medical negligence on the part of the Hospital, its employees, and the physicians as its ostensible agents.

FACTS

Wanda Y. Johnson was injured May of 1992, when she was struck by a vehicle while walking. The parties agree that her injuries were life threatening and that she was critically ill. She was taken to the Hospital where she received treatment for her injuries over the course of the next two months. During her stay at the Hospital, she remained in a weakened state. She suffered a series of infections including pneumonia and urinary tract infections.

In July of 1992, the Hospital sought to transfer Johnson to a nursing home facility. Prior to her discharge, she demonstrated the symptoms of an active infection. She was placed on an antibiotic treatment and transferred on July 24, 1992, to Crestview, a licensed nursing facility. The day after arriving at Crestview, Johnson was taken from the nursing home and admitted to Midwest Medical Center, an Indianapolis hospital. She remained at that facility for several months.

Johnson has no medical insurance. Her hospital bills while at the Hospital surpassed the $300,000 mark.

I

A party moving for summary judgment has the burden of showing that there are no genuine issues of fact and that the movant is entitled to summary judgment as a matter of law. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 151-60, 90 S. Ct. 1598, 16 L. Ed. 2d 142 (1970); *Felix v. Young*, 536 F.2d 1126, 1134 (6th Cir. 1976). Not every factual dispute

between the parties will prevent summary judgment. The disputed facts must be material. They must be facts which, under the substantive law governing the issue, might affect the outcome of the suit. *Anderson v. Liberty Lobby, Inc.*, 106 S.Ct. 2505, 2510 (1986). The dispute must also be genuine. The facts must be such that if they were proven at trial, a reasonable jury could return a verdict for the non-moving party. *Id.* at 2510. The disputed issue does not have to be resolved conclusively in favor of the non-moving party, but that party is required to present some significant probative evidence which makes it necessary to resolve the parties' differing versions of the dispute at trial. *First National Bank of Arizona v. Cities Service Co.*, 391 U.S. 253, 288-89 (1968). The evidence must be construed in a light most favorable to the party opposing the motion. *Bohn Aluminum & Brass Corp. v. Storm King Corp.*, 303 F.2d 425 (6th Cir. 1962).

The Hospital has moved for summary judgment, addressing Counts 1, 2, and 3 of the complaint. We will consider each of these arguments.

II

Count 1 of the complaint alleges that the defendant violated § 1395dd, when it transferred Johnson to Crestview.

Section 1395dd is designed to keep hospitals from "dumping" patients in need of emergency medical care. It provides that when any individual comes to the emergency department of a hospital and a request is made for a screening, an appropriate medical screening must be provided

to determine whether an emergency medical condition exists. If an emergency medical condition is found, the hospital must either provide stabilizing treatment or transfer the individual in accordance with the requirements of the statute. The plaintiff contends that the Hospital violated part (b) of § 1395dd in that it failed to stabilize her and transferred her without conforming with the requirements of part (c). The Hospital argues that it provided stabilizing treatment, that Johnson was stable when she was transferred to Crestview, and that the plaintiff has failed to prove that the Hospital acted with an improper motive. Therefore, the Hospital contends, summary judgment is warranted on this count.

The plaintiff does not allege that the screening given by the Hospital in May, 1992 was inappropriate. Furthermore, it is undisputed that at the time Johnson arrived at the Hospital she presented an emergency medical condition. The parties disagree on the issues of whether Johnson was stabilized when she was transferred to Crestview and whether the Hospital acted with an improper motive. We will address both issues.

A

If Johnson was stable when she was transferred, then the Hospital did not violate § 1385dd(b). This is a material fact.

The Hospital presents the affidavits of the treating physicians and those involved in Johnson's discharge. They are in agreement that Johnson was stable when she was

transferred to Crestview.

Plaintiff presents the testimony of Dr. Stuy, the physician who treated Johnson at Midwest Medical Center in Indianapolis. Portions of Dr. Stuy's deposition testimony follow:

> Q. All right. Doctor we're -- we're talking about what is expected or what is reasonable medical care in a situation where a doctor has identified what appears to be active infection and has prescribed antibiotic treatment for that infection. Is there a certain period of time that you normally would expect to have to monitor a patient to determine whether the antibiotics that you have prescribed are going to adequately treat the infection that you found?
>
> A. Well, what you would typically do is obtain a culture of the potential source of infection. So in this case, you would obtain a sample of urine and send it to the laboratory for culture and sensitivity; by that, the laboratory would try to grow bacteria to see if there is an active infection, identify those bacteria and then they can in the laboratory check various antibiotics and see if those antibiotics would successfully kill or eliminate

> those bacteria. So you identify the organism then you can actually check a number of antibiotics and see if those are successful in treating that particular infection.
>
> Q. Generally is this something that takes a period of days?
>
> A. Within 48 hours they should be able to render a preliminary report and within 72 hours they should be able to give a positive identification
>
> Q. If a physician does not follow through with this analysis of the antibiotic treatment that he's administered, would that generally in your opinion be outside the normal standard of good medical care?
>
> A. . . . I think in this particular patient because she is immunocompromised, she's lacking a spleen, also the fact that she has a predisposition to pneumonia, she has a predisposition to urinary tract infection because of a catheter residing in her bladder and the fact that she's been in the hospital a long time and, therefore, exposed to bacteria

and organisms that are not typically more easily treated, I think she should have had a culture obtained and looked at prior to her release to be sure that antibiotic would address that infection successfully.

Q. Dr. Stuy, based on your review of Wanda Johnson's medical records from the University of Louisville during the last couple of days that she was there, was her condition such that -- that she required continuous medial attention in a hospital setting?

A. I think, as I mentioned previously, that cultures of the presumed infection should have been obtained and looked at first prior to transfer to be sure that the antibiotics that they picked would successfully treat that infection. If they picked an antibiotic that would not successfully treat an infection and she were released, because of her generally immunocompromised state, lack of spleen, prolonged hospital stay, foreign bodies in the form of catheters, there is some risk that the infection would get worse and could cause her harm.

(Text omitted)

Q. All right. Was Wanda Johnson's medical condition such that if she did not have available to her medical attention her condition could possibly have deteriorated very quickly?

A. Yes.

Q. Describe again for us the types of health risks or conditions that under Wanda Johnson's condition she may have suffered from, not necessarily that she did suffer from, but the risks that she -- that were involved in her condition.

A. Her ability to fight off infection was compromised. If the infection were not to be checked or treated with the antibiotics successfully, it could spread into the bloodstream and cause a condition called sepsis which if not treated quickly can result in death.

Q. Doctor, based on your experience and treatment of Wanda Johnson and your

review of her medical records at Humana Hospital, University of Louisville, do you have an opinion as to whether Wanda Johnson's transfer from Louisville to Indianapolis on July 24, 1992 was consistent with accepted medical standard of care?

A. I don't think it was.

Q. Doctor, would the risks that you've previously told us about, would a -- trip in an ambulance from Louisville to Indianapolis, that period of time that it would take to -- to travel that distance, would you consider that a dangerous situation for Wanda Johnson in her condition?

A. I think she should have remained in the hospital setting until they could document that the antibiotics that they picked could successfully treat the suspected infection.

Q. Doctor, could you tell us a little bit about what injuries, if any, or what deterioration in Wanda Johnson's condition you noticed as having been caused by her transfer from the University of Louisville

Hospital?

A. When I met her Saturday morning, she had a very high fever, she was breathing very rapidly, clinically she demonstrated evidence of pneumonia and by x-ray she also demonstrated evidence of pneumonia. Her white blood cell count was high. She was flushed, sweaty, hot. I felt she demonstrated all the physical findings and laboratory findings consistent with early sepsis or overwhelming infection.

Q. And --

A. If this is not treated, then it results in death.

Q. Doctor, was Wanda Johnson's condition substantially worse when you saw her on Saturday morning than what it appeared to have been just prior to her transfer from the University of Louisville Hospital?

A. Her res -- yes, based on the notes that I read, her -- her respiratory rate was very rapid, her pulse was very rapid, her pulse was

very rapid, her temperature was 105 at the nursing home just prior to transfer to the hospital which is higher than at the hospital -- Humana Hospital, so yes, she was worse than -- than at Humana.

A key issue in this case is whether Johnson was "stabilized." "The term 'stabilized,' means that 'no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a [hospital]' 42 U.S.C. Section 1395dd(e)(4)(B)." *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990). Dr. Stuy's testimony does not mirror the language of the statute. However, it can be read to express the belief that Johnson was not stable, due to her apparent infection, immunocompromised state, and prior history of infections. Furthermore, there is evidence that Dr. Stuy's opinion was not based solely on the outcome. Dr. Stuy testified that considering Johnson's immunocompromised condition, the signs of infection, and her medical history she should not have been transferred when she was. Therefore, the plaintiff's contention that she was not stable is based on facts existing at the time of her discharge, not "only on the outcome."

Viewing the evidence in the light most favorable to the non-moving party, we find that there is a genuine issue of a material fact with regard to the issue of stabilization.

B

The Hospital also contends that it did not act with an improper motive. The Sixth Circuit recognizes the presence of an improper motive as an essential element in a claim for relief under § 1395dd. *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990). This requirement applies to stabilization with even greater force. *Id.* A hospital violates the statute where it refuses treatment or gives cursory treatment to a person for improper reasons. *Id.* at 272. Without proof of an improper motive, failure to stabilize is not actionable under the statute. *Cleland*, 917 F.2d 266; *Hines*, 827 F. Supp. 426.

The plaintiff offers the testimony of Joanna Nolte, the Crestview patient recruiter. Nolte spoke with Nancy Fred, a social worker with the Hospital, concerning placement of Johnson in a nursing home. An excerpt from Nolte's deposition testimony follows:

> Q. Okay. Tell us how you first learned of a patient named Wanda Johnson.
>
> A. The social worker that was handling her case asked me if I would be willing to take a look at a patient that they had been trying to discharge and without any avail to other facilities and that she was getting a lot of pressure to discharge this person due to they knew they were not going to get paid for

this person.

Q. Do you recognize the name Nancy Fred?

A. Correct, it was Nancy Fred.

This statement is admissible under Rule 801(d)(2)(D) as non-hearsay, since it is a statement offered against a party and was allegedly made "by the party's agent or servant concerning a matter within the scope of the agency or employment, made during the existence of the relationship. . . ." There is a difference of opinion concerning whether this statement was ever made. However, viewing this evidence in the light most favorable to the plaintiff, it does tend to establish a genuine issue of fact concerning whether the Hospital acted with an improper motive.

The Hospital argues that the decision to transfer Johnson was a medical choice and was not influenced by Johnson's apparent indigence. This argument presents an issue as to causation, which is not presently before the court. The Hospital's argument essentially is that regardless of the administration's motive, the doctors themselves made an independent medical decision to transfer the patient. Therefore, they contend that, since the transfer was not effected due to an improper motive, the Hospital cannot be held liable under the statute. *See, e.g. Hines*, 827 F. Supp.

426. Since the causation issue is not squarely before us, we must confine our ruling to those issues directly in contention.

The plaintiff has established that there is a genuine question of fact with regard to the issue of improper motive on the part of the Hospital. Therefore, the Hospital's motion for summary judgment will be denied with regard to this count.

III

Count 2 of the complaint alleges that the Hospital acted under color of state law when it transferred Johnson to Crestview. Therefore, the plaintiff contends, the Hospital was required to comply with the constitutional requirements of equal protection and due process.

In order to proceed with these claims, the plaintiff must satisfy the state action requirement of the Fourteenth Amendment. *Blum v. Yaretsky*, 457 U.S. 991 (1982). "That amendment erects no shield against merely private conduct, however discriminatory or wrongful." *Id.* at 1002.

The Supreme Court has set forth the following three tests to determine whether challenged conduct amounts to state action: (1) the public function test; (2) the state compulsion test; and (3) the symbiotic relationship or nexus test. *Wolotsky v. Huhn*, 960 F.2d 1331, 1335 (6th Cir. 1992) (citations omitted). The plaintiff argues that under either the public function or nexus test, the Hospital's conduct was state action.

The plaintiff first attempts to establish that the

Hospital is fulfilling a public function. The test requires that "the private entity exercise powers which are traditionally exclusively reserved to the state . . . ." *Wolotsky v. Huhn*, 960 F.2d 1331, 1335 (6th Cir. 1992). However, the provision of hospital services is not a power which has traditionally been exclusively reserved to the state. Moreover, the plaintiff has not established that in the absence of the Hospital, the state is required to provide these hospital services. *See, Blum*, 457 U.S. at 1011. Therefore, the Hospital is not fulfilling a public function.

Next, the plaintiff asserts that "there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." Plaintiff's Memorandum at 30 (citing *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974)). The plaintiff contends that since (1) the hospital was previously operated by the University, (2) the University expressed certain desires in its agreements with the Hospital, (3) the Hospital received appropriations from the state, and (4) the Hospital participated in Medicaid, there was a sufficient nexus between the state and the Hospital to amount to state action.

The ultimate issue is whether the alleged infringement of rights is "fairly attributable to the state." *Crowder v. Conlan*, 740 F.2d 447, 449 (6th Cir. 1984). In *Crowder*, a physician sued a private hospital for civil rights violations alleged to have occurred in the restriction of his staff

privileges. *Id.* The *Crowder* court found no state action in the hospital's decision where the hospital received considerable revenues from the government, the hospital was subject to extensive regulation, and the hospital's physical plant was owned by the county and leased to the defendant. The court noted that the county was not involved in the day-to-day operations of the hospital nor was it involved in the challenged action. *Id.*

In *Blum*, the issue before the Court was whether state action attaches to a nursing facility's summary discharge or transfer of a patient. *Blum*, 457 U.S. 991. The nursing homes in question were receiving federal funds for at least 90% of their patients. *Id.* Although the plaintiff in *Blum* actually sued state officials for the conduct of private parties, the reasoning applies in the instant case as well. *Crowder*, 740 F.2d at 450. The Court in *Blum* noted, "[t]hat programs undertaken by the State result in substantial funding of the activities of a private entity is no more persuasive than the fact of regulation of such an entity in demonstrating that the State is responsible for decisions made by the entity in the course of business." *Blum*, 457 U.S. at 1011 (holding that neither substantial regulation nor funding of a private enterprise amounted to state action). The Court found that the plaintiffs had failed to establish state action, because the decisions were independently made by private individuals. *Id.* at 1008. The state had not exercised such coercion or given encouragement that the choice must be deemed that of

the state. *Id.* at 1004.

The United States Supreme Court and the Sixth Circuit Court of Appeals have found state action lacking in similar circumstances. We find state action lacking here as well. As in *Blum* and *Crowder* the decision in this case to transfer Johnson was not that of the state but that of the privately owned and operated hospital.

Therefore, the defendant's motion with respect to this count will be granted.

IV

Count 3 of the complaint alleges negligence on the part of the Hospital through its corporate acts, the acts of its employees, and the acts of the doctors as its "ostensible agents."

The Hospital challenges the allegations in this count on the ground that the medical residents were not the ostensible agents of the Hospital. The uncontroverted evidence is that the Hospital required conscious patients to sign a form acknowledging the independent status of physicians. The Hospital asserts that it did not hold itself out as ostensible employer of the medical residents and should not be liable for their alleged negligence.

It is apparent from a review of the Kentucky cases concerning ostensible agency that the manner in which the principal (the Hospital) holds itself out to the public is controlling. In *Williams v. St. Clare Medical Center*, 657 S.W.2d 590 (Ky. App. 1983), the court of appeals adopted

ostensible agency to hold a hospital liable for the negligence of an independent contractor nurse. The *Williams* court noted:

> Apparent authority is not actual authority, but rather "is that which, by reason of prevailing usage or other circumstance, the agent is in effect held out by the principal as possessing. It is a matter of appearance, fairly chargeable to the principal and by which persons dealt with are deceived, and on which they rely.

Id. at 595 (quoting *Estell v. Barrickman*, 571 S.W.2d 650, 652 (Ky. App. 1978). By taking no action to give notice to the contrary, the defendant in *Williams* held out the nurse as its employee and was held liable for his negligence.

This theory was applied to emergency room doctors by the Supreme Court of Kentucky in *Paintsville Hosp. Co. v. Rose*, 683 S.W.2d 255 (Ky. 1985). In that case, the court held that a "general representation to the public [was] implied from the circumstances." *Id.* at 256. Although proof of reliance on the part of the unconscious patient was lacking, the court found the emergency room doctor to be the ostensible agent of the hospital, focussing on the appearance, the representations, and the manifestations of the principal and its apparent agent. *Id.* at 257.

The Kentucky courts recognize that the determining factor in a question of ostensible agency is whether the

principal holds out the third party as its agent. The undisputed evidence in this case is that the Hospital did not hold out these doctors as its agents. In fact, it required each conscious patient to sign an admission form acknowledging that the doctors were in fact independent contractors.[1] According to the *Rose* court, where the hospital holds out the doctors as its agents, the plaintiff need not prove actual reliance to establish apparent agency. Conversely, when the evidence demonstrates that the hospital as a matter of routine practice disclaims an agency relationship with its resident doctors, apparent agency is not shown even if the patient is unconscious and does not specifically receive notice of the disclaimer. Just as reliance is not necessary to prove apparent agency if the hospital does not routinely disclaim it, reliance is not necessary to disprove apparent agency where the hospital's routine is to disclaim it.

The test is whether the Hospital held out these doctors as its agents. The undisputed evidence is that it did not. Therefore, the defendant's motion for summary judgment with regard to this portion of Count 3 will be granted.

---

[1]*See, e.g., Floyd v. Humana of Virginia, Inc.*, 787 S.W.2d 267, 270 (Ky. App. 1989), *discr. rev. denied* (holding that where the plaintiff had signed a form acknowledging the independent status of the doctors and there was no representation or other action to induce one to believe that the doctors were the agents of the hospital, there can be no valid argument that the ostensible agency doctrine should apply.)

CONCLUSION

The Hospital has moved for partial summary judgment. As to Count 1 of the complaint, there are material issues of fact with regard to the issues as presented to the court. Therefore, the Hospital's motion will be denied for that count. However, the plaintiff did not establish state action, and accordingly the motion will be granted as to Count 2. As to Count 3, the doctrine of ostensible agency does not apply to the Hospital in relation to the independent contractor doctors involved in treating Johnson at the Hospital. Therefore, the Hospital's motion will be granted with regard to that portion of Count 3 which asserts a claim under the theory of ostensible agency.

An order in accordance with this opinion will be entered this date.

This 13th day of November, 1995.

/s/Charles R. Simpson III
Charles R. Simpson III
Chief Judge
United States District Court

cc: Counsel of Record

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — PLAINTIFF

v. — CIVIL ACTION NO. 3:93CV-544-S

GALEN OF VIRGINIA, INC., d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — DEFENDANT

ORDER

This matter having come before the court on the motion of the defendant for partial summary judgment, and the court having considered said motion and being otherwise sufficiently advised, **IT IS HEREBY ORDERED**:

1. That the defendant's motion with respect to count 1 of the complaint is **DENIED**.

2. That the defendant's motion with respect to count 2 of the complaint is **GRANTED** and that count is **DISMISSED WITH PREJUDICE**.

3. That the defendant's motion with respect to that portion of count 3 as asserts a claim against the defendant for the alleged negligence of the independent contractor

physicians under the doctrine of ostensible agency is **GRANTED**, and that portion of count 3 is **DISMISSED WITH PREJUDICE**.

4. Inasmuch as count 1 of the complaint has not been dismissed, this court retains federal question jurisdiction, and the defendant's motion to remand is **DENIED**.

IT IS SO ORDERED this 13th day of November, 1995.

/s/ Charles R. Simpson III
Charles R. Simpson III,
Chief Judge
United States District Court

cc: Counsel of Record

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — PLAINTIFF

v. — CIVIL ACTION NO. 3:93CV-544-S

GALEN OF VIRGINIA, INC., d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — DEFENDANT

MEMORANDUM OF OPINION

This matter is before the court on the motion of the defendant for reconsideration of the court's order dated November 13, 1995. In that order we denied the defendant's motion for summary judgment with respect to count 1 of the complaint and further denied the defendant's motion for remand.

We discussed the relevant facts in our previous memorandum opinion and see no need to repeat them here.

I

In its previous memoranda, the defendant argued that since it did not act with an improper motive, the plaintiff's claim must fail. We did not consider the defendant's

argument concerning causation, as it was not squarely before us. However, the defendant's motion for reconsideration raises this argument and we will now address it.

A hospital may be liable under the Emergency Medical Treatment and Active Labor Act (EMTALA) for "failing to stabilize" a patient's condition prior to transferring the patient. *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) (quoting *DeBerry v. Sherman Hosp. Assoc.*, 741 F. Supp. 1302 (N.D. III. 1990). However, the plaintiff must establish that discriminatory motive caused the failure to stabilize. *Cleland*, 917 F.2d at 271. EMTALA provides protection not from medical malpractice but from discriminatory treatment or transfer. *Id.* at 272 (noting that EMTALA does not apply to hospital which acts in the same manner as it would for the usual paying patient).

We determined in our prior opinion in this matter that there was an issue of fact with regard to whether Johnson was stable when she was transferred. We also noted that the plaintiff presented some evidence as to an improper motive on the part of the defendant hospital. However, we expressly confined our decision to those issues and did not address the issue of causation.

The defendant contends that the decision to transfer Wanda Y. Johnson was based entirely on her medical condition, as determined by her physicians who were unaware of her financial status. It presents the affidavits of the doctors responsible for Johnson's discharge. Defendant's

Memorandum, Ex. B (affidavits of Drs. Richardson, Harbrecht, and Abou-Jaoude). Each of these doctors states that Johnson was stable when she was transferred. They also state that her financial condition did not affect their medical decision to authorize her transfer.

If "[i]n the hospital's opinion, the patient was stable, and they would have believed that a patient with any differing characteristics would have been stable[,] "then" within the meaning of the Act [EMTALA] the hospital did its duty to stabilize" Johnson. *Cleland*, 917 F.2d at 271. This is true even if it turns out the "patient was in fact not stabilized[.]" *Hines*, 827 F. Supp. at 431 (explaining *Cleland*, which held that hospital fulfilled its obligation although the patient was later determined not to have been stable).

The defendant has the burden of showing that there were no genuine issues of fact and that it is entitled to summary judgment as a matter of law. *Adickes v S.H. Kress & Co.*, 398 U.S. 144, 151-60 (1970); *Felix v. Young*, 536 F.2d 1126, 1134 (6th Cir. 1976). In this case the defendant presented evidence tending to negate the causative effect of any improper motive held by the defendant. Thus, the plaintiff was required to present some significant probative evidence making it necessary to resolve the parties' differing versions of the dispute at trial. *First National Bank of Arizona v. Cities Service Co.*, 391 U.S. 253, 288-89 (1968). Yet, the plaintiff presented no evidence that either the medical opinion that Johnson was stable or the decision to authorize

her transfer was caused by an improper motive. There is no issue as to this material fact and summary judgment is warranted.

For the foregoing reasons, the defendant's motion for reconsideration will be granted. The EMTALA claim in count 1 of the complaint will be dismissed.

The defendant, in its original motion for summary judgment, asked the court to remand. Remand in this case is improper, inasmuch as the suit was originally filed with this court. Yet, the plaintiff filed this suit invoking our federal question jurisdiction, and all that remains of the plaintiffs complaint is a claim for medical negligence under state law. "Needless decision of state law should be avoided both as a matter of comity and to promote justice between the parties, by procuring for them a surer-footed reading of applicable law." *United Mine Workers of America v. Gibbs*, 383 U.S. 715, 726 (1966). The *Gibbs* court noted that where state claims are before the court on pendent jurisdiction, "if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well." *Id.*

For the above reasons, the federal EMTALA claim in count 1 of the complaint will be dismissed with prejudice and the pendent state law claim in what remains of count 3 will be dismissed for lack of jurisdiction in this court.

An order in accordance with this opinion will be entered this date.

This 15th day of February, 1996.

/s/ Charles R. Simpson III
Charles R. Simpson III
Chief Judge
United States District Court

cc: Counsel of Record

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — PLAINTIFF

v. — CIVIL ACTION NO. 3:93CV-544-S

GALEN OF VIRGINIA, INC., d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — DEFENDANT

ORDER

This matter having come before the court on the motion of the defendant for reconsideration of the court's order dated November 13, 1995, and the court having considered said motion and being otherwise sufficiently, **IT IS HEREBY ORDERED:**.

1. The motion is **GRANTED** and the federal EMTALA claim in count 1 of the complaint is **DISMISSED WITH PREJUDICE**.

2. The sole remaining claim under what remains of count 3 of the complaint asserts a state law cause of action. That count is **DISMISSED WITHOUT PREJUDICE. FEDERAL QUESTION JURISDICTION IS LACKING.**

IT IS SO ORDERED.

This 15th day of February, 1996.

/s/ Charles R. Simpson III
Charles R. Simpson III
Chief Judge
United States District Court

cc: Counsel of Record

42 U.S.C. § 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor. (1) In general. If any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either -

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection

(c).

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection © and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

© **Restricting transfers until individual stabilized.** (1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning

of subsection (e)(3)(B)), the hospital may not transfer the individual unless -

(A)(I) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1) [42 USCS § 1395x(r)(1)]) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1) [42USCS § 1395x(r)(1)]), in consultation with the person, has made the determination described in such

clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer -

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility -

(I) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

© in which the transferring hospital sends to the receiving facility with all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's

emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement. (1) Civil monetary penalties. (A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such

provisions apply with respect to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who -

> (I) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or
>
> (ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this title [42 USCS §§ 1395 et seq.] and State health care programs. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same

manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

© If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I) [42 USCS § 1395cc(a)(1)(I)]) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement. (A) Personal harm. Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this

section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

© Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations. In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI [42 USCS §§ 1320c et seq.]) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) Definitions. In this section:

(1) The term "emergency medical condition" means -

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -

(I) placing the health of the

individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women who is having contractions -

(I) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 [42 USCS § 1395cc].

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a

facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a rural primary care hospital (as defined in section 1861(mm)(1) [42 USCS § 1395x(mm)(1)]).

(f) Preemption. The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination. A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to

rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment. A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination or treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(I) Whistleblower protections. A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of this section.

(Aug. 14, 1935, ch 531, Title XVIII, Part C, § 1867, as added April 7, 1986, P. L. 99-272, title IX, Subtitle A, Part 1, Subpart B, § 9121(b), 100 Stat. 164; Oct. 21, 1986, P. L. 99-514, Title XVIII, Subtitle C, Ch 1, § 1895(b)(4), 100 Stat. 2933; Dec. 22, 1987, P. L. 100-203, Title IV, Subtitle A, Part 1, § 4009(a)(1), (2), 101 Stat. 1330-56; July 1, 1988, P. L. 100-360, Title IV, Subtitle B, § 411(b)(8)(A)(I), 102 Stat. 772); Oct. 13, 1988, P. L. 100-485, title VI, § 608(d)(18)(E), 102 Stat. 2419; Dec. 19, 1989, P. L. 101-239, Title VI,

Subtitle A, Part 1, Subpart A, § 6003(g)(3)(D)(xiv), Part 3, Subpart B, § 6211(a)-(h), 103 Stat. 2154; Nov. 5, 1990, P. L. 101-508, Title IV, Subtitle A, Part 1, § 4008(b)(1)-(3)(A), Part 3, § [4207]4027(a)(1)(A), (2), (3), (k)(3), 104 Stat. 1388-44, 1388-117, 1388-124.)

(3)

Supreme Court, U.S.
FILED
AUG 6 1997
CLERK

No. 97-53

In The

Supreme Court of the United States

October Term, 1996

JANE M. ROBERTS, Guardian for Wanda Y. Johnson,

Petitioner,

v.

GALEN OF VIRGINIA, INC.,
d/b/a University of Louisville Hospital,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

BRYAN TODD THOMPSON
Counsel of Record
for Respondent
DINSMORE & SHOHL LLP
2000 Meidinger Tower
Louisville, KY 40202
(502) 585-2450

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED FOR REVIEW

Petitioner seeks this Court's review based on the following framed questions:

Whether a claim under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, requires proof of an improper motive as a prerequisite for recovery.

Whether, if proof of an improper motive is a prerequisite for recovery under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, a causal relationship must exist between the hospital employee possessing the alleged improper motive and the discharge of the unstable patient.

Whether, under Kentucky law, resident physicians not directly employed by the hospital, are the hospital's ostensible agents whose negligence can be attributed to the hospital.

PARTIES TO THE PROCEEDING

The parties to this proceeding are as named in the Petition and this Brief in Opposition.

TABLE OF CONTENTS

	Page
Questions Presented for Review	i
Parties to the Proceeding	ii
Table of Contents	iii
Table of Authorities	iv
Opinions Below	1
Jurisdiction	1
Statute Involved	1
Statement of the Case	2
Reason for Denying the Petition	6
Conclusion	11

TABLE OF AUTHORITIES

Page

CASES:

Baber v. Hospital Corp., 977 F.2d 872 (4th Cir. 1992) 8

Clelend v. Bronson Health Care Group, 917 F.2d 266 (6th Cir. 1990) 6

Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995) 6, 9

Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991) 6

Power v. Arlington Hosp. Ass'n, 42 F.3d 851 (4th Cir. 1994) 6, 10

Roberts v. Galen of Virginia, Inc., 111 F.3d 405 (6th Cir. 1997) 6, 7

Summers v. Baptist Medical Center Arkadelphia, 91 F.3d 1132 (8th Cir. 1996) 8, 9

Vickers v. Nash General Hosp., 78 F.3d 139 (4th Cir. 1996) 7, 8, 9

STATUTES AND OTHER AUTHORITIES:

Emergency Medical Treatment and Active Labor Act, 42 USC § 1395dd 1, 2

RESPONDENT'S BRIEF IN OPPOSITION

Respondent, Galen of Virginia, Inc. d/b/a University of Louisville Hospital ("Humana"), respectfully requests that the Court deny the Petition for Writ of Certiorari seeking review of the April 9, 1997, Opinion Affirming rendered by the United States Court of Appeals for the Sixth Circuit.

OPINIONS BELOW

The Opinion Affirming of the United States District Court, Western District of Kentucky, at Louisville, is reprinted at Appendix A1 to the Petition. The Memorandum Opinions of the United States District Court, Western District of Kentucky, at Louisville, are reprinted at Appendix A26 and A48 to the Petition.

JURISDICTION

Petitioner invokes this Court's jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The Statute involved in this case is the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, reprinted at Appendix A55 to the Petition.

STATEMENT OF THE CASE

On August 30, 1993, Petitioner, as guardian for Wanda Y. Johnson ("Johnson"), filed this action in the United States District Court for the Western District of Kentucky under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (Supp. 1996), alleging that Humana Hospital University of Louisville ("Humana") failed to comply with EMTALA in the transfer of Johnson to a skilled nursing facility. Johnson also alleged that Humana should be liable for negligence under state-law for the acts of the surgical residents responsible for Johnson's care.

Johnson was hospitalized at Humana on May 19, 1992 after sustaining injuries in a motor vehicle accident. Johnson remained hospitalized at Humana for over two months during which time she experienced numerous complications associated with immobility and trauma. During the last few weeks of Johnson's hospitalization, her physicians – who are not employed by Humana – determined that her condition had stabilized, and that Johnson was in need of long term care and rehabilitation in a skilled nursing facility.

Placing Johnson was difficult because of a long-standing shortage of nursing home beds in Kentucky. Johnson's husband, Michael Johnson, was informed of the situation by Humana's social workers and verbally authorized Humana to look for appropriate facilities in neighboring Indiana.

On July 22, 1992, a representative from Crestview Health Care Center ("Crestview") in Indianapolis, Indiana, came to Humana and evaluated Johnson for placement in that facility. Crestview represented that it provided skilled nursing care, physical, speech and occupational therapy services, and would be able to do so for Johnson. Crestview's admissions team reviewed Johnson's records and accepted her for admission. Johnson was transferred to Crestview on July 24, 1992.

On the day before Johnson's transfer, she developed the symptoms of a urinary tract infection, including an elevated temperature. Johnson's physicians treated the suspected infection with an antibiotic and although Johnson's temperature remained elevated on the day of her discharge, Johnson's physicians were aware of her condition and did not feel her transfer to a skilled nursing facility was contraindicated.

The physicians involved in Johnson's care attested that Johnson's condition was sufficiently stable to warrant discharge. These physicians further attested that the decision to discharge Johnson was a medical one and that her financial condition was not a consideration. Johnson brought forth no evidence suggesting that Johnson's treating physicians were aware of her financial condition.

Johnson also alleged that the hospital violated several policies and procedures pertaining to the transfer or discharge of patients. Humana offered proof that the policies Johnson referred to either did not apply to her or were substantially complied with.

Following Johnson's transfer from Humana, and approximately two hours after her arrival at Crestview,

Crestview's Director of Nursing assessed Johnson's condition. She believed that Johnson's condition was sufficiently stable to be treated at Crestview. Johnson's admitting physician at Crestview felt that Johnson was stable upon arrival to Crestview based on the information he received from Crestview's nursing staff.

Despite orders that Johnson's vital signs had to be checked every four hours, the Crestview personnel did not reassess her until 15 1/2 hours following her admission – at which time a significant deterioration in Johnson's condition was discovered. Johnson was transferred to an Indianapolis hospital where she was treated by John Stuy, M.D. ("Dr. Stuy"). According to Dr. Stuy, Johnson's tracheostomy tube should have been suctioned by Crestview's nursing staff at least every four hours or more often as needed. Failure to suction a patient can result in aspiration of fluids or mucous plugging which can lead to pneumonia. Yet, Crestview's records show that Johnson was not suctioned during the last eleven hours of her stay at Crestview. Dr. Stuy, who reviewed Johnson's records from Humana, acknowledged that Johnson's condition changed significantly the day after she was transferred from Humana.

The District Court initially denied Humana's motion for summary judgment on the EMTALA claim because it found there was a genuine issue of material fact as to whether Johnson was stabilized before she was transferred and because there was a genuine issue of material fact as to whether Humana acted with an improper motive. Regarding the state-law negligence claim, the District court held that Humana could not be liable for the actions of the surgical residents because they were

not ostensible agents of the hospital. Humana moved for reconsideration of the EMTALA claim. On reconsideration, the District Court held that, despite the existence of genuine issues of material fact as to stabilization and improper motive, Johnson failed to offer any proof that "either the medical opinion that Johnson was stable or the decision to authorize her transfer was caused by an improper motive." Thus, the District Court granted Human's motion for summary judgment on the EMTALA claim. Johnson appealed the dispositions of the EMTALA claim and the District court's conclusion that the residents were not ostensible agents of Humana.

On appeal, the Sixth Circuit held that proof of an improper motive is a prerequisite to recovery under EMTALA. Although Johnson alleged that a Humana social worker received pressure from Humana administration to make discharge arrangements for Johnson because she lacked insurance, Johnson brought forth no evidence that her treating physicians – who alone had the authority to discharge Johnson – acted with an improper motive in ordering her discharged. Accordingly, the Sixth Circuit held that the District Court properly granted summary judgment on Johnson's EMTALA claim because she failed to show any evidence of a causal relation between the hospital employee allegedly possessing the improper motive and Johnson's discharge. The Sixth Circuit further held that the District court properly concluded that the surgical residents responsible for Johnson's care were not ostensible agents of Humana.

REASONS FOR DENYING THE PETITION

Johnson attempts to assert a medical negligence action under the guise of an alleged EMTALA violation, which is contrary to the purpose of the statute. Congress's sole purpose in enacting EMTALA was to deal with the problem of patient "dumping", i.e., refusing for non-medical reasons to treat or inappropriately transferring patients presenting for care in hospital emergency departments. EMTALA is not a substitute for state-law malpractice actions, nor does it guarantee proper diagnosis or provide a federal remedy for medical negligence. The circuits are uniformly in accord on the need to distinguish EMTALA claims from state negligence and medical malpractice claims. *See, e.g., Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) ("EMTALA does not create a cause of action for federal malpractice."); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994) ("EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence."); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (EMTALA is not intended "to ensure each emergency room patient a correct diagnosis, but rather to ensure that each is accorded the same level of treatment regularly provided to patients in similar medical circumstances.")

The Sixth Circuit has held that a showing of improper motive is a prerequisite to recovery under EMTALA. *Roberts v. Galen of Virginia, Inc.*, 111 F.3d 405 (6th Cir. 1997); *Clelend v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990). Absent a showing of improper

motive, EMTALA becomes "nothing more than a federal remedy for medical malpractice." *Roberts*, 111 F.3d at 410.

Johnson argues that this Court should issue a Writ of Certiorari in this case because the Sixth Circuit's interpretation of EMTALA is clearly divergent from other circuit courts that have construed EMTALA. The Courts of Appeal for the District of Columbia Circuit, the First Circuit, the Fourth Circuit, and the Eighth Circuit have adopted a "disparate treatment" test that does not, on its face, require a showing of improper motive. Instead, courts using the disparate treatment analysis examine whether an EMTALA claimant received treatment different from other "similarly situated patients." Johnson suggests that an EMTALA claimant can prevail under this test simply by showing that a hospital did not conform to its policies and procedures in treating a patient.

In actuality, improper motive or bias is implicit within the disparate treatment analysis, and the distinction between the tests utilized by the circuit courts is one of semantics. A recent Fourth Circuit case is illustrative. In *Vickers v. Nash General Hosp.*, 78 F.3d 139, 144 (4th Cir. 1996), the Fourth Circuit held that "EMTALA is implicated only when individuals who are **perceived** to have the same medical condition receive disparate treatment; it is not implicated whenever individuals who turn out **in fact** to have had the same condition receive disparate treatment." (Emphasis in original.) The court emphasized that:

> In fact, not only does treatment based on diagnostic medical judgment not violate the Act, it is precisely what EMTALA hoped to achieve – handling of patients according to an assessment

> of their medical needs, without regard to extraneous considerations such as their ability to pay.

Id.

The *Vickers* court noted that the physician had treated plaintiff for the condition he perceived – mainly, a scalp laceration – and that he did not believe testing for intracranial injury was medically necessary. Accordingly, the hospital did not violate EMTALA because the seriousness of the condition was not "actually perceived," although it was possible that the physician may have been negligent. *Id.* at 144-45. Regarding the claim for failure to stabilize, the *Vickers* court stated that " '[a]nalysis by hindsight . . . is not sufficient to impose liability under EMTALA.' " *Id.* at 145 (citing *Baber v. Hospital Corp.*, 977 F.2d 872, 883 (4th Cir. 1992)). Further, that "a hospital must actually perceive the seriousness of the medical condition and nevertheless fail to act to stabilize it." *Vickers*, 78 F.3d at 145. Clearly, failure to act in the face of a recognized serious medical condition implicates improper motive and effectively limits the statute's application to only those cases that involve bias or discrimination.

Likewise, the Eighth Circuit acknowledged that something more than a deviation from a hospital's normal screening process is required to prevail under EMTALA. *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996). The plaintiff in *Summers* fell from a deer stand while hunting and claimed that he complained of pain and heard popping noises in his chest while being examined in the hospital's emergency department. The physician treating the plaintiff did not recall

plaintiff complaining of chest pain or popping noises in the chest. The physician ordered x-rays of the spine, but not the chest, and determined the plaintiff was suffering from muscle spasms. Two days later, the plaintiff went to another hospital and was diagnosed with various chest fractures. The hospital conceded that patients complaining of chest pain or popping noises in their chest would normally be given a chest x-ray. *Id.* at 1135-36.

The *Summers* court admitted it had previously adopted the position that a hospital's failure to follow its procedures amounted to disparate treatment and was violative of EMTALA. *Id.* at 1338. On reflection, the court concluded that a mere allegation of non-uniform treatment "is nothing more than an accusation of negligence." *Id.* at 1139. Instead, the court held that:

> instances of 'dumping,' or improper screening of patients for a discriminatory reason, or failure to screen at all, or screening a patient differently from other patients perceived to have the same condition, all are actionable under EMTALA. But instances of negligence in the screening or diagnostic process, or of mere faulty screening, are not.

Id.

It is inconceivable that the disparate treatment test as modified by the courts in *Vickers* and *Summers* could be met absent some evidence of bias or improper motive. In fact, among the circuits that have adopted the disparate treatment analysis, only those cases involving at least circumstantial evidence of bias have been permitted to go forward. *See Correa*, 69 F.3d at 1184, 1189 (affirming jury

verdict for plaintiff where plaintiff alleged denial of treatment after the hospital viewed the patient's insurance card); *Power*, 42 F.3d at 854 (affirming jury verdict for plaintiff who was unemployed and uninsured). What possible explanation, other than bias or improper motive, can there be for a hospital's refusal to treat one patient with a perceived emergency medical condition in the same manner it would treat other patients with the same condition?

Johnson's argument that claimants in the Sixth Circuit are required to prove more than claimants elsewhere, is inaccurate. Regardless of jurisdiction, all EMTALA claimants must show that a hospital denied them screening or stabilizing treatment that patients perceived to have the same condition would have received. It is immaterial whether the test requires proof of improper motive versus proof of disparate treatment of a perceived emergency medical condition. Essentially, the same proof is required. There is no "clear divergence" among the circuits interpreting EMTALA. The only difference is the name given the analysis used. Accordingly, there is no compelling reason for this Court to issue a Writ of Certiorari in this case.

CONCLUSION

Respondent Humana respectfully requests that the Petition be denied.

Respectfully submitted,

BRYAN TODD THOMPSON
Counsel of Record for Respondent
DINSMORE & SHOHL LLP
2000 Meidinger Tower
Louisville, KY 40202
(502) 585-2450

Supreme Court, U.S.
FILED
MAR 13 1998
CLERK

(4)

No. 97-53

In the Supreme Court of the United States

OCTOBER TERM, 1997

JANE M. ROBERTS, GUARDIAN FOR WANDA Y. JOHNSON,
PETITIONER

v.

GALEN OF VIRGINIA, INC., FORMERLY DBA HUMANA
HOSPITAL—UNIVERSITY OF LOUISVILLE, DBA
LOUISVILLE HOSPITAL

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

SETH P. WAXMAN
Solicitor General
Counsel of Record

FRANK W. HUNGER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
Assistant to the Solicitor General

BARBARA C. BIDDLE
CARL E. GOLDFARB
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

25 pp

QUESTION PRESENTED

Whether a claim brought under the private cause of action provision of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd(d), requires proof of an improper motive as a prerequisite for recovery.

TABLE OF CONTENTS

	Page
Statement	1
Discussion	10
Conclusion	20

TABLE OF AUTHORITIES

Cases:

Burditt v. *U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991)	10, 11, 12
Butner v. *United States*, 440 U.S. 48 (1979)	20
Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)	19
Cleland v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990)	6, 7, 8, 13, 17
Correa v. *Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996)	2, 14
Eberhardt v. *City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995)	14, 18
Gatewood v. *Washington Health Care Corp.*, 933 F.2d 1037 (D.C. Cir. 1991)	13, 14
Holcomb v. *Monahan*, 30 F.3d 116 (11th Cir. 1994)	15, 18
Huddleston v. *Dwyer*, 322 U.S. 232 (1944)	20
Marshall v. *East Carroll Parish Hospital Service District*, 134 F.3d 319 (5th Cir. 1998)	15
Martin v. *OSHRC*, 499 U.S. 144 (1991)	19
Power v. *Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994)	14, 15
Repp v. *Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994)	15
Summers v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996)	14, 18

Statutes, regulations, and rule: Page

Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd *et seq.*:
- 42 U.S.C. 1395dd 1
- 42 U.S.C. 1395dd(a) 2, 8, 10, 12, 13, 14, 15, 17, 18
- 42 U.S.C. 1395dd(b) 8, 9, 11, 13, 15, 17, 19
- 42 U.S.C. 1395dd(b)(1) 10
- 42 U.S.C. 1395dd(b)(1)(A) 2
- 42 U.S.C. 1395dd(c) 3
- 42 U.S.C. 1395dd(d)(1)(A) 3, 4, 12, 16
- 42 U.S.C. 1395dd(d)(1)(B) 3, 4, 12, 16
- 42 U.S.C. 1395dd(d)(2) 12
- 42 U.S.C. 1395dd(d)(2)(A) 4, 12
- 42 U.S.C. 1395dd(d)(2)(B) 4, 12
- 42 U.S.C. 1395dd(d)(3) 18
- 42 U.S.C. 1395dd(d)(3)(1)(A) 4
- 42 U.S.C. 1395dd(d)(3)(1)(B) 4
- 42 U.S.C. 1395dd(e)(1) 2
- 42 U.S.C. 1395dd(e)(2) 1
- 42 U.S.C. 1395dd(e)(3)(A) 3
- 42 U.S.C. 1395dd(e)(3)(B) 3
- 42 U.S.C. 1395dd(e)(4) 3

42 U.S.C. 1320a-7a 4
42 U.S.C. 1395f(c) 2
42 U.S.C. 1395y(a)(3) 2
42 U.S.C. 1395cc(a)(1) 1
42 U.S.C. 1395cc(a)(1)(I) 1, 16
42 U.S.C. 1395cc(b)(2) 4
42 U.S.C. 1395cc(b)(2)(A) 17
42 U.S.C. 1395qq 2
42 C.F.R. (1997):
- Section 489.24 2
- Section 489.24(f) 16
- Section 489.53(b) 16

Sup. Ct. R. 14.4 19

—

Miscellaneous:

59 Fed. Reg. (1994):
- p. 32,086 19
- p. 32,104 19

The Random House Dictionary of the English Language (2d ed. 1987) 18
Webster's Third New International Dictionary (1986) 18

In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-53

JANE M. ROBERTS, GUARDIAN FOR WANDA Y. JOHNSON, PETITIONER

v.

GALEN OF VIRGINIA, INC., FORMERLY DBA HUMANA HOSPITAL—UNIVERSITY OF LOUISVILLE, DBA LOUISVILLE HOSPITAL

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is filed in response to this Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. The Emergency Medical Treatment and Active Labor Act (EMTALA) , 42 U.S.C. 1395dd, imposes two principal obligations on hospitals with Medicare provider agreements. 42 U.S.C. 1395dd(e)(2).[1]

---

[1] The statutory scheme governing the Medicare program requires participating hospitals to comply with the requirements of EMTALA. 42 U.S.C. 1395cc(a)(1)(I). Almost all non-federal hospitals have Medicare provider agreements. See

First, when an individual comes to a covered hospital and a request is made on the individual's behalf for examination or treatment for a medical condition, the Act requires the hospital to provide "an appropriate medical screening examination within the capability of the hospital's emergency department * * * to determine whether or not an emergency medical condition * * * exists." 42 U.S.C. 1395dd(a). The Act does not define the term "appropriate medical screening examination." The term "emergency medical condition" is defined as a condition "manifesting itself by acute symptoms of sufficient severity * * * that the absence of immediate medical attention could reasonably be expected to result in * * * serious jeopardy [to the health of the individual or her unborn child], * * * serious impairment to bodily functions, or * * * serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1); see generally 42 C.F.R. 489.24.

Second, if the hospital determines that an individual who has come to the hospital is suffering from an emergency condition, the hospital must either provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or transfer the patient to another hospital in accordance with the provisions of subsection (c). 42 U.S.C. 1395dd(b)(1)(A); see generally 42 C.F.R. 489.24. The term "to stabilize" means "to provide such medical treatment of the [emergency medical] condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual." 42 U.S.C. 1395dd(e)(3)(A). The term "stabilized" is defined accordingly. 42 U.S.C. 1395dd(e)(3)(B).

Correa v. *Hospital San Francisco*, 69 F.3d 1184, 1191 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996) ("ninety-nine percent of American hospitals [are] covered by EMTALA"). With the exception of hospitals managed by the Indian Health Service, federally run hospitals are ineligible to enter into Medicare provider agreements. 42 U.S.C. 1395f(c); 42 U.S.C. 1395qq; 42 U.S.C. 1395y(a)(3).

Subsection (c) states that "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized * * *, the hospital may not transfer the individual unless" the individual (or a legal representative) makes an informed, written request to be transferred; a physician has signed a certification indicating that the medical benefits reasonably expected from a transfer outweigh the risks; or, if a physician is not available, a qualified medical person, in consultation with a physician, has made the required risk/benefits determination. 42 U.S.C. 1395dd(c). Subsection (c) further provides that in order for such a transfer to be appropriate, any receiving hospital must agree to accept the transfer of the individual and to provide appropriate medical treatment, and the sending hospital must forward all relevant medical records. 42 U.S.C. 1395dd(c). The Act defines "transfer" to include "discharge" of the individual. 42 U.S.C. 1395dd(e)(4).

A participating hospital that negligently violates a requirement of the Act is subject to a civil money penalty of not more than $50,000 for each such violation. 42 U.S.C. 1395dd(d)(1)(A). A physician who negligently violates a requirement of the Act with regard to an individual in a participating hospital is similarly subject to a civil monetary penalty of not more than $50,000 for each such violation. 42 U.S.C. 1395dd(d)(1)(B). If the violation is "gross and flagrant

or repeated," the physician is also subject to exclusion from participation in Medicare and state health care programs. *Ibid.* See also 42 U.S.C. 1395cc(b)(2). Civil money penalties and exclusions are imposed by the Secretary of Health and Human Services, pursuant to 42 U.S.C. 1320a-7a, as incorporated into 42 U.S.C. 1395dd(d)(1)(A) and (B).

The Act also provides for two private rights of action against participating hospitals, but not against physicians. The Act provides that "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [EMTALA]" may bring a civil action to obtain those damages that are available for personal injury under the law of the State in which the hospital is located, as well as for appropriate equitable relief against the hospital. 42 U.S.C. 1395dd(d)(2)(A). The Act further provides that "[a]ny medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of [EMTALA] may" also bring a civil action for those damages that are available for financial loss under the law of the State in which the hospital is located, as well as for appropriate equitable relief. 42 U.S.C. 1395dd(d)(2)(B).

2. Wanda Y. Johnson was injured in May 1992 when she was struck by a vehicle while walking. Her injuries were life threatening, and she was taken to respondent hospital, where she received treatment for the next two months. She suffered a series of infections and other complications, including pneumonia and urinary tract infections. Pet. App. A27.

In July 1992, respondent sought to transfer Johnson, who had no medical insurance, to a nursing home facility. At the time, she had symptoms of an active infection. She was placed on antibiotics and transferred on July 24, 1992, to Crestview, a licensed nursing facility in Indiana after two other nursing homes turned Johnson down following on-site evaluations of her condition by their directors of nursing. Pet. App. A2, A27. Before discharging and transferring Johnson to Crestview, respondent did not take a urine sample to send to the laboratory for culture, nor did it seek to determine whether the antibiotics would kill or eliminate the bacteria causing Johnson's infection. *Id.* at A30-A31. The day after she arrived at Crestview, Johnson's condition deteriorated and she was transported to Midwest Medical Center, an Indianapolis hospital, where she remained for several months, incurring expenses in excess of $300,000. *Id.* at A27. The State of Indiana rejected Johnson's application for medical assistance under the Indiana Medicaid Program because Johnson failed to meet the state residency requirements. *Id.* at A3.

3. On August 30, 1993, petitioner, as guardian for Johnson, filed suit in the United States District Court for the Western District of Kentucky, alleging that respondent had violated EMTALA by transferring Johnson to Crestview before the hospital had stabilized her condition. Petitioner, Johnson's aunt, did not allege that the initial screening that Johnson received was inappropriate, and respondent did not dispute that when Johnson arrived at the hospital she presented an emergency condition. Pet. App. A29.

In a memorandum opinion, entered on November 13, 1995, the district court denied respondent's motion for summary judgment on the EMTALA claim. Pet. App. A45.[2] The court concluded that there was a genuine

[2] Petitioner's complaint also alleged, in Count 2, that respondent acted under color of state law when it transferred Johnson and thus had to comply with constitutional requirements of

issue of material fact as to whether Johnson was stabilized at the time of transfer. *Id.* at A36, A39. Citing the Sixth Circuit's decision in *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (1990), which the district court described as requiring "the presence of an improper motive as an essential element in a claim for relief under § 1395dd," the district court held that there was also a disputed issue of material fact as to whether the hospital acted with improper motive in transferring Johnson. Pet. App. A37.

The court based its ruling as to improper motive on a statement that a hospital social worker was facing considerable pressure to have Johnson discharged because the hospital was not being paid for her care. Pet. App. A37-A38.[3] Respondent moved for reconsid-

due process and equal protection. Pet. App. A39, A45. The district court granted respondent summary judgment on that claim after determining that respondent did not act under color of state law in transferring Johnson. *Id.* at A42, A46. The court of appeals did not rule on that claim, and petitioner does not present it in this Court. The complaint also alleged, in Count 3, negligence under state law on the part of respondent through its corporate acts, the acts of its employees, and the acts of the doctors as its "ostensible agents." *Id.* at A42. The district court granted respondent summary judgment on that count insofar as it rested on the assertion that the doctors were agents of the hospital, after concluding that the doctors were not the ostensible or apparent agents of the hospital. *Id.* at A43-A44. The court of appeals affirmed that holding. *Id.* at A16-A23. The district court dismissed the remaining portion of Count 3 without prejudice after it rejected petitioner's claims under federal law, *id.* at A53, and that portion of Count 3 apparently was not at issue on appeal.

[3] Joanna Nolte, a representative of Crestview Health Care Facility, testified that Nancy Fred, a social worker employed by respondent, explained to her that "they had been trying to

eration, and in support of its motion, submitted affidavits from the doctors responsible for Johnson's discharge. The doctors all stated that Johnson was stable when transferred and that her financial condition did not influence their medical decision to authorize her transfer. *Id.* at A49-A50. The district court granted summary judgment to respondent because "the plaintiff presented no evidence that either the medical opinion that Johnson was stable or the decision to authorize her transfer was caused by an improper motive[]." *Id.* at A51.

4. The court of appeals affirmed the district court's judgment. Pet. App. A1-A25. The court of appeals stated that the district court "properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under EMTALA." *Id.* at A10. The court noted that *Cleland* defined the term "appropriate medical screening" not to refer to malpractice or some other standard of care, but rather to refer "to the motives with which the hospital acts." *Id.* at A8-A9 (quoting *Cleland*, 917 F.2d at 272). The court further noted that the *Cleland* court concluded that a showing of improper motive was not limited to a refusal to treat patients because of indigence but also included "prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (*e.g.*, AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or

discharge and without any avail to other facilities and that she was getting a lot of pressure to discharge this person due to they knew they weren't going to get paid for this person." Pet. App. A14.

political or cultural opposition." *Id.* at A9-A10 (quoting *Cleland*, 917 F.2d at 272).

The court of appeals reasoned that a plaintiff must prove improper motive in order to distinguish an EMTALA claim from a state law claim for malpractice. The court explained:

> We reject the position espoused by [petitioner] that, to succeed on a claim under the EMTALA, she can prove that [respondent's] treatment of Johnson was not uniform to patients suffering the same medical condition as Johnson. Proof of disparate treatment, in [petitioner's] view, distinguishes an EMTALA claim from a state law negligence claim. If we were to adopt this position, however, we would effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable standard of care with respect to all similarly situated patients. In other words, we would require a hospital to prove that it has committed medical negligence or malpractice.

Id. at A11.

The court acknowledged that the issue in *Cleland* was whether the hospital had afforded the patient an "appropriate medical screening" in accordance with subsection (a) of EMTALA, while the issue in the current case is whether the hospital failed to stabilize a patient with an emergency medical condition in violation of subsection (b) of EMTALA. Pet. App. A12 n.3. The court also noted that the term "appropriate medical screening," the linchpin of the court's analysis in *Cleland*, appears in subsection (a) but not in subsection (b). Nonetheless, explaining that it "s[aw] no rational reason to set forth differing standards

when applying subsection (a) and (b)," *ibid.*, the court of appeals concluded that *Cleland*'s improper motive requirement also applies in cases like this that arise under subsection (b).

As to the merits of the controversy before it, the court of appeals first noted that, under *Cleland*, physicians "are charged with stabilizing a patient's condition as it is known to them." Pet. App. A13. And the court further noted that respondent did not dispute that there was a genuine issue of material fact as to whether Johnson was stabilized when she was discharged by respondent. *Id.* at A14. The court nevertheless affirmed the district court's award of summary judgment for respondent, concluding that the district court correctly found that petitioner had failed to introduce evidence of improper motive that led to Johnson's discharge. *Id.* at A14-A16. Although the court acknowledged the evidence of the statement by the hospital social worker that she was facing pressure to discharge Johnson, the court emphasized that the social worker played no role in determining whether Johnson was in stable condition before she was discharged, and that affidavits of the physicians who were involved stated that Johnson's financial status played no role in the discharge decision. See *ibid.*

Judge Nelson dissented in part. Pet. App. A23-A25. In his view, evidence of petitioner's treating physician that he relied on the hospital's social workers, together with evidence that the social workers were "receiving pressure from [respondent's] administration to get * * * Johnson discharged," *id.* at A25, was sufficient to raise "a genuine issue of fact as to whether [respondent] acted from an improper motive," *id.* at A24.

DISCUSSION

The Sixth Circuit's decision in this case directly conflicts with the Fifth Circuit's decision in *Burditt* v. *United States Department of Health and Human Services*, 934 F.2d 1362, 1372 (1991), which held that improper motive need not be shown in a similar improper transfer case arising under Section 1395dd(b)(1). Moreover, the reasoning employed by the Sixth Circuit in this case, which depends directly on that court's previous holding in *Cleland* that a plaintiff must prove improper motive in order to prevail in an "appropriate medical screening" case brought under Section 1395dd(a), conflicts with decisions of the three other courts of appeals that have expressly rejected an improper motive requirement under that provision. That reasoning also is inconsistent with decisions of the four other courts of appeals that have defined the scope of EMTALA liability with no mention of an improper motive requirement. No other circuit has followed the Sixth Circuit in requiring proof of improper motive to establish a violation of EMTALA.

The issue presented in this case is of substantial importance. Because it can be very difficult to prove "improper motive," the scope of an EMTALA private action in the Sixth Circuit at present is substantially narrower than the scope of such an action elsewhere in the country. Moreover, the Sixth Circuit's decision will predictably make it more difficult for the Secretary to assess civil monetary penalties on offending hospitals or physicians in the Sixth Circuit than elsewhere in the country; hospitals or physicians in the States in the Sixth Circuit will argue that they have not violated the Act, and therefore do not become liable for civil penalties, unless the

Secretary shows that they acted out of improper motives. Accordingly, the petition for a writ of certiorari should be granted.

1. The decision of the Sixth Circuit directly conflicts with the Fifth Circuit's decision in *Burditt*. In that case, a physician transferred a patient in active labor to another hospital without ensuring that the patient's condition was "stabilized" under EMTALA. The court of appeals affirmed a civil penalty assessed against the physician by the Secretary under EMTALA. The court noted that the physician "asks this court to invent a requirement found nowhere in the statute that an improper, or nonmedical, motive for transfer must be proved as an element of all EMTALA transfer violations." 934 F.2d at 1373. The court explained, however, that "[a]s written, EMTALA prevents patient dumping without such a requirement," and the court "refuse[d] to alter the statutory scheme." *Ibid.*

The Fifth Circuit's decision in *Burditt* is directly contrary to the Sixth Circuit's decision in this case. Like *Burditt*, this case involves an EMTALA claim under Section 1395dd(b) that a patient was improperly transferred from a hospital before the patient's condition was stabilized. Yet, the Sixth Circuit in this case expressly noted that its previous decision in *Cleland* "requir[es] that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA," and, contrary to *Burditt*, extended that requirement to an improper transfer claim under Section 1395dd(b), see Pet. App. A12 n.3.

It is true that *Burditt* arose from a challenge to an EMTALA civil penalty imposed by the Secretary, rather than a private damages action under EMTALA. But the Fifth Circuit nowhere relied on

any differences between government enforcement actions and private suits under EMTALA.[4] Indeed, the Fifth Circuit's holding that the improper motive requirement is "found nowhere in the statute," *ibid.*, necessarily rejected the proposition that improper motive is an element of either a government enforcement action or a private suit under EMTALA.

2. The reasoning of the Sixth Circuit's decision in this case also conflicts with decisions of the three other courts of appeals that have expressly refused to inject an improper-motive requirement into an EMTALA cause of action under the Section 1395dd(a) "appropriate medical screening" provision. In addition, the Sixth Circuit's decision conflicts with decisions of four additional courts of appeals whose treatment of EMTALA Section 1395dd(a) claims has made clear that the Act imposes no such requirement.

The Sixth Circuit did not purport to find any language in Section 1395dd(b) that could be construed to

---

[4] At the time *Burditt* was decided, the Act required the government to show that a violation was made "knowingly" before imposing a civil penalty. See *Burditt*, 934 F.2d at 1373-1374. Since then, the Act has been amended, and it now requires the government to prove negligence before imposing a civil penalty. See 42 U.S.C. 1395dd(d)(1)(A) and (B). The neighboring provision governing private suits, however, imposes no express requirement that the plaintiff show that a violation was intentional, knowing, or even negligent. 42 U.S.C. 1395dd(d)(2)(A) and (B). That difference suggests that a private plaintiff can prevail on a lesser showing than would be required to impose a civil penalty; it would not support any conclusion that a private plaintiff must make the greater showing of improper motive required by the court of appeals. (The Act provides that a civil penalty may be imposed on a hospital, 42 U.S.C. 1395dd(d)(1)(A), or on a physician, 42 U.S.C. 1395dd(d)(1)(B), while a private plaintiff is given a cause of action only against a hospital, 42 U.S.C. 1395dd(d)(2).)

impose an improper motive requirement. Instead, it relied heavily on its prior decision in *Cleland*, which arose under Section 1395dd(a)'s "appropriate medical screening" provision and held that "'appropriate' must * * * be interpreted to refer to the motives with which the hospital acts." 917 F.2d at 272. The court in this case applied that holding to Section 1395dd(b) because it "s[aw] no rational reason to set forth differing standards when applying subsection[s] (a) and (b)." Pet. App. A12 n.3. Accordingly, the Sixth Circuit's conclusion that "a plaintiff [must] prove a hospital acted with an improper motive in order to recover under the EMTALA," *id.* at A10, rests, at bottom, on the construction in *Cleland* of the term "appropriate medical screening" in Section 1395dd(a).

No court of appeals has agreed with the Sixth Circuit that Section 1395dd(a) requires a plaintiff to show improper motive as an element of an EMTALA screening claim. Three courts of appeals have expressly rejected the contention that a plaintiff must show that the deficiency in medical screening was due to the presence of an improper motive. For example, in *Gatewood* v. *Washington Health Care Corp.*, 933 F.2d 1037 (1991), the D.C. Circuit held that "a hospital fulfills the 'appropriate medical screening' requirement when it conforms in its treatment of a particular patient to its standard screening procedures." *Id.* at 1041. The court specifically rejected any requirement that a violation depends on whether the hospital acted in bad faith, noting that "any departure from standard screening procedures constitutes inappropriate screening in violation of [EMTALA]," and that "[t]he motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care

provided others." *Ibid.* In *Power* v. *Arlington Hospital Association*, 42 F.3d 851, 857 (4th Cir. 1994), which also arose from a claim of inappropriate medical screening under Section 1395dd(a), the Fourth Circuit stated that it was "persuaded that the D.C. Circuit's rejection of an improper motive requirement is indeed the correct approach." And in *Summers* v. *Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (1996), the en banc Eighth Circuit cited the D.C. Circuit's decision in *Gatewood* approvingly, stated that it "depart[ed] from the reasoning of *Cleland*," and held that "[i]f a hospital fails to provide an appropriate medical screening examination, it is liable, no matter what the motivation was for this failure." *Id.* at 1137-1138.

Four other courts of appeals, while not expressly addressing a claim that improper motive must be shown, have formulated the EMTALA inquiry in "appropriate medical screening" cases in ways that are inconsistent with the Sixth Circuit's construction of the Act. Those courts have all concluded that the appropriateness of a medical screening procedure under EMTALA depends on whether it is evenhandedly administered to all patients whose medical conditions are in relevant respects similar, not on proof of the motivation with which the hospital or doctor acted in failing to follow standard screening procedures. See *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) ("The essence of this requirement is that there be some screening procedure, and that it be administered evenhandedly."), cert. denied, 517 U.S. 1136 (1996); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("[T]he test is whether the challenged procedure was identical to that provided similarly situated patients."); *Repp* v. *Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) ("[A] hospital satisfies the requirements of § 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances."); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) ("As long as a hospital applies the same screening procedures to indigent patients which it applies to paying patients, the hospital does not violate [Section 1395dd(a)]."); see also *Marshall* v. *East Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998) ("[A]n EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms.").

3. The Sixth Circuit's decision significantly adds to the plaintiff's burden in an EMTALA case. As courts have recognized, a requirement that a plaintiff establish a hospital's motivation in failing to satisfy the "appropriate medical screening" standard of Section 1395dd(a), or in failing to satisfy the "stabilization" or medically necessary transfer provisions of Section 1395dd(b), would impose a very substantial burden. Regardless of whether the Fourth Circuit was correct in its assessment that "having to prove the existence of an improper motive on the part of a hospital, its employees or its physicians, would make a civil EMTALA claim virtually impossible," *Power*, 42 F.3d at 858, it would at least put civil EMTALA plaintiffs in the Sixth Circuit at a severe disadvantage relative to plaintiffs elsewhere in the country.[5]

---

[5] For this reason, we disagree with respondent's contention that "improper motive or bias is implicit within the disparate treatment analysis, and the distinction between the tests util-

Moreover, the Sixth Circuit's decision easily could be read to affect the EMTALA enforcement authority of the Department of Health and Human Services. EMTALA provides that HHS may assess a civil penalty against a hospital or doctor who "negligently violates a requirement of [EMTALA]." 42 U.S.C. 1395dd(d)(1)(A) and (B). Under the Sixth Circuit's ruling, hospitals and doctors can be expected to claim that, in addition to showing negligence, HHS must show improper motivation before it can assess a civil penalty. Indeed, a physician defendant has already made that argument in a case currently on appeal in the Sixth Circuit, *Cherukuri* v. *Secretary of Health and Human Services*, No. 97-4464. The Sixth Circuit's decisions in *Cleland* and in this case will also make it more difficult for the Secretary to exclude hospitals from the Medicare program under the authority granted in 42 U.S.C. 1395cc(a)(1)(I) and (b)(2)(A) (see 42 C.F.R. 489.53(b), 489.24(f)), because

---

ized by the circuit courts is one of semantics." Br. in Opp. 7. There is a substantial difference between the Sixth Circuit's requirement "that a plaintiff prove a hospital acted with an improper motive," Pet. App. A10, and the law in other circuits, which permits a plaintiff to show that the statutory standard was violated through inappropriate screening or a failure to stabilize without shouldering the further burden of proving the underlying motive with which the hospital acted. Indeed, the Sixth Circuit affirmed the award of summary judgment to respondent in this case (even though it found a genuine issue of material fact on the question whether petitioner's condition was stabilized) on the ground that petitioner had failed to produce "evidence of a causal relation between the hospital employee possessing the improper motive [*i.e.*, a desire not to treat patients who could not afford to pay] and the discharge of the unstable patient." *Id.* at A16. Such proof would have been unnecessary to withstand a summary judgment motion in the other circuits that have addressed the issue.

defendants will argue that they may not be excluded unless it can be shown that they had an improper motive in violating the Act and applicable regulations.

4. In our view, the Sixth Circuit's holding that an EMTALA violation occurs only if the hospital acted from an improper motive is wrong. The Sixth Circuit did not purport to base its holding on any language in Section 1395dd(b), and no language in that provision provides support for that requirement. Section 1395dd(b) requires that a hospital either "must provide * * * such treatment as may be required to stabilize the medical condition" or must provide "for transfer to another medical facility in accordance with subsection (c)." 42 U.S.C. 1395dd(b). Nothing in that language (or in subsection (c)) suggests that a hospital is excused from liability for a failure to adhere to those requirements, so long as it does so without an improper motive.

Insofar as the Sixth Circuit's decision rests on anything beyond its own view of relevant policy considerations regarding the scope of the EMTALA cause of action, see Pet. App. A10-A11, it rests on that court's construction of the term "appropriate" in Section 1395dd(a) in *Cleland*. Even if that term could be construed to impose an improper motive requirement in cases under Section 1395dd(a), it would provide no basis to impose such a requirement in cases arising under Section 1395dd(b). Although the court of appeals could find no "rational reason" for distinguishing between the two provisions, *id.* at A12 n.3, the difference in statutory language would be sufficient to make such a distinction. More fundamentally, as all of the other courts of appeals to address the issue have decided, the term "appropriate" in 42 U.S.C. 1395dd(a) itself refers to the type of

screening provided to an emergency room patient, not to the motivation underlying a medical screening that fails to satisfy the Act.[6] The word "appropriate" is susceptible to a wide range of meanings, but construing it to mean "without improper motivation" is to confer on the word a meaning not found in any standard dictionary and not known to common usage.[7]

The Secretary of Health and Human Services has construed the relevant EMTALA provisions and has concluded that improper motive is not an essential element of a violation. In the preamble to Interim Final Rules and Regulations that remain in effect and that govern the Department's Health Care Financing Administration and its Office of Inspector General,

[6] There appears to be some disagreement in the courts of appeals regarding whether Section 1395dd(a)'s requirement of an "appropriate medical screening examination" imposes a substantive minimum standard of care or whether instead it merely imposes a requirement that a hospital provide the same care to all patients whose conditions are similar. Compare *Correa*, 69 F.3d at 1192 (screening must be "reasonably calculated to identify critical medical conditions") and *Eberhardt*, 62 F.3d at 1258 ("The touchstone is whether * * * the [screening] procedure is designed to identify an 'emergency medical condition,' that is manifested by 'acute' and 'severe' symptoms.") with *Summers*, 91 F.3d at 1138 ("An inappropriate screening examination is one that has a disparate impact on the plaintiff.") and *Holcomb*, 30 F.3d at 117 ("As long as a hospital applies the same screening procedures to indigent patients which it applies to paying patients, the hospital does not violate [Section 1395dd(a)]."). Because this case does not arise under Section 1395dd(a), that issue is not presented here.

[7] See *e.g.*, *The Random House Dictionary of the English Language* 103 (2d ed. 1987) (defining "appropriate" as "suitable or fitting for a particular purpose, person, occasion"); *Webster's Third New International Dictionary* 106 (1986) ("specially suitable: fit, proper").

the Secretary stated: "Also with regard to appropriate transfers, we note that the Secretary has taken the position that in proving that a hospital or physician violated [42 U.S.C. 1395dd(b)], there is no requirement to prove that the transfer was effected due to some 'impermissible motive.'" 59 Fed. Reg. 32,086, 32,104 (1994). As the regulations note, that position was not a new one, since it had already been accepted by the Fifth Circuit three years earlier in *Burditt*. See p. 11, *supra*. HHS administers the civil monetary fine program created by EMTALA, see 42 U.S.C. 1395dd(d)(3). Accordingly, because HHS's interpretation is reasonable, it deserves deference. See *Martin* v. *OSHRC*, 499 U.S. 144 (1991); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-845 (1984).

5. In addition to the basic question regarding whether improper motive must be shown in an EMTALA suit, the petition for a writ of certiorari seeks further review of two other questions. See Pet. i. Those questions are not discussed in the body of the petition. Failure to include any facts or argument on those issues precludes a "ready and adequate understanding of the points requiring consideration," and is therefore a "sufficient reason" for denying the petition as to those issues. Sup. Ct. R. 14.4.

In any event, neither of the two additional questions warrants review by this Court. One of them concerns whether an EMTALA plaintiff who must prove improper motive under Sixth Circuit precedent must show that the motive affected the discharging physician, in addition to the hospital administration and social services staff. The Sixth Circuit appears to have held, however, not that the improper motive must be shown to have affected the discharging

physician, but that the improper motive must be shown to have affected the decision to discharge the patient. See Pet. App. A16 (petitioner did not produce "evidence of a causal relation between the hospital employee possessing the improper motive and the discharge of the unstable patient"). Accordingly, the question as framed in the petition is not presented in this case.

The other question listed in the petition has to do with whether surgical residents are a hospital's agents under Kentucky law. That question appears to relate to the court of appeals' ruling on petitioner's pendent state law negligence claim. See Pet. App. A16-A23. Such questions of state law do not warrant review by this Court. *Butner* v. *United States*, 440 U.S. 48, 58 (1979); *Huddleston* v. *Dwyer*, 322 U.S. 232, 237 (1944).

CONCLUSION

The petition for a writ of certiorari should be granted with respect to the first question presented.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
FRANK W. HUNGER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General
BARBARA C. BIDDLE
CARL E. GOLDFARB
Attorneys

MAY 1998

Supreme Court, U.S.
FILED
JUL 23 1998
OFFICE OF THE CLERK

(5)

No. 97-53

In The

Supreme Court of the United States

October Term, 1997

JANE M. ROBERTS, Guardian for Wanda Y. Johnson,

Petitioner,

vs.

GALEN OF VIRGINIA, INC., Formerly d/b/a Humana Hospital – University of Louisville,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

JOINT APPENDIX

JOSEPH H. MATTINGLY III*
104 West Main Street
P.O. Box 678
Lebanon, Kentucky 40033
Telephone: (502) 692-1718

Counsel for Petitioner

BRYAN TODD THOMPSON*
DINSMORE AND SHOHL, LLP
200 Meidinger Tower
Louisville, Kentucky 40202
Telephone: (502) 585-2450

Counsel for Respondent

Counsel of Record

Petition For Certiorari Filed July 8, 1997
Certiorari Granted June 8, 1998

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

142 pp

ROBERTS vs. GALEN OF VIRGINIA, INC.
(No. 97-53) CONTENTS OF JOINT APPENDIX

Page

Relevant Docket Entries..... 1

Humana Hospital – University of Louisville Policy Procedure No. 0418 (8/84)..... 3

Humana Hospital – University of Louisville Policy Procedure No. 0420 (8/1/84)..... 5

Humana Hospital – University of Louisville Policy Procedure No. 768-0901 (6/15/85)..... 11

Humana Hospital – University of Louisville Policy Procedure No. 768-0912 (7/10/91)..... 16

Extracts of Deposition of Nancy Fred taken November 22, 1993..... 19

Extracts of Deposition of Jo Anna Nolte taken January 24, 1994..... 41

Extracts of Deposition of Charna Y. Treser taken January 25, 1994..... 55

Extracts of Deposition of John W. Stuy, M.D., taken January 25, 1994..... 62

Extracts of Deposition of Kambiz T. Karimi, M.D., taken July 12, 1994..... 80

Extracts of Deposition of Taiseer Shatara, M.D., taken July 12, 1994..... 85

Extracts of Deposition of Frank Miller, M.D., taken January 25, 1995..... 94

Extracts of Deposition of John W. Stuy, M.D., taken March 28, 1995..... 107

ROBERTS vs. GALEN OF VIRGINIA, INC.
(No. 97-53) CONTENTS OF JOINT APPENDIX – Continued

Page

Extracts of Deposition of Walid A. Abou-Jaoude, M.D., taken March 31, 1995 116

Affidavit of David Richardson, M.D., dated March 10, 1995 131

Affidavit of Walid Abou-Jaoude, M.D., dated March 15, 1995 133

Affidavit of Brian Harbrecht, M.D., dated April 7, 1995 135

Affidavit of Nancy Fred, M.S.W., dated May 1, 1995 137

ROBERTS vs. GALEN OF VIRGINIA, INC. **(No. 97-53)**
NOTATION TO COURT OF LOCATION OF OPINIONS AND ORDERS

The following opinions, decisions, judgments, and orders have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the printed petition for certiorari:

Page

Memorandum Opinion of the United States District Court for the Western District of Kentucky, dated November 13, 1995 ..... A26

Order of the United States District Court for the Western District of Kentucky, dated November 13, 1995 ..... A46

Memorandum Opinion of the United States District Court for the Western District of Kentucky, dated February 15, 1996 ..... A48

Order of the United States District Court for the Western District of Kentucky, dated February 15, 1996 ..... A53

Opinion of the United States Court of Appeals for the Sixth Circuit, dated April 9, 1997 ..... A1

RELEVANT DOCKET ENTRIES
ROBERTS *vs.* GALEN OF VIRGINIA, INC. (No. 97-53)

Humana Hospital – University of Louisville Policy Procedure No. 0418 (8/84)

Humana Hospital – University of Louisville Policy Procedure No. 0420 (8/1/84)

Humana Hospital – University of Louisville Policy Procedure No. 768-0901 (6/15/85)

Humana Hospital – University of Louisville Policy Procedure No. 768-0912 (7/10/91)

Extracts of Deposition of Nancy Fred taken November 22, 1993

Extracts of Deposition of Jo Anna Nolte taken January 24, 1994

Extracts of Deposition of Charna Y. Treser taken January 25, 1994

Extracts of Deposition of John W. Stuy, M.D., taken January 25, 1994

Extracts of Deposition of Kambiz T. Karimi, M.D., taken July 12, 1994

Extracts of Deposition of Taiseer Shatara, M.D., taken July 12, 1994

Extracts of Deposition of Frank Miller, M.D., taken January 25, 1995

Extracts of Deposition of John W. Stuy, M.D., taken March 28, 1995

Extracts of Deposition of Walid A. Abou-Jaoude, M.D., taken March 31, 1995

Affidavit of David Richardson, M.D., dated March 10, 1995

Affidavit of Walid Abou-Jaoude, M.D., dated March 15, 1995

Affidavit of Brian Harbrecht, M.D., dated April 7, 1995

Affidavit of Nancy Fred, M.S.W., dated May 1, 1995

Humana Hospital
University of Louisville
POLICY PROCEDURE

No. -0418
Effective Date
8/ ___ /84

Subject:

DISCHARGE CRITERIA
CRITICAL CARE COMPLEX

PURPOSE:

To establish guidelines for the transfer/discharge of patients from the Critical Care Complex.

POLICY STATEMENT:

Patients are discharged/transferred from the Critical Care Complex only with the order of a physician and when the need for intensive care or intermediate care no longer exists.

Prior to discharge/transfer patients will meet all of the following criteria:

1) Absence of Arterial Line
2) Absence of Pulmonary Artery Catheter
3) Absence of Intercranial Pressure Monitoring Device
4) Absence of life threatening dysrhythmias
5) Absence of severe Acid Base Imbalance (pH less than 7.2 or Greater than 7.6)

6) Absence of life threatening electrolyte imbalance

7) Absence of Acute respiratory failure. PA02 less than 60 (with or without supplemental oxygen therapy)

8) Absence of severe hypotension or hypertension – B/P stable – maintained without vaso active drips.

9) Absence of Blakemore Tube

In addition to the above, the Burn Unit also requires:

1) Wound reduced to 10% or less of total body surface area and free of active signs of wound infection

2) Patient or responsible person is able to carry out wound care and physical therapy as instructed (patient/responsible person has reviewed unit discharge booklet)

3) Patient is able to return to Clinics or arrangements have been made with other physicians for follow-up care.

Patients requiring an intermediate level of care are to be transferred to Transitional Care Unit. This includes all patients requiring: (See TCU Admission Policy #0417-E)

1) Cardiac monitoring

2) IV Antidysrhythmic drips

3) Tracheal suctioning every hour

4) Major treatments or dressing changes lasting 45" or more (2-3 times daily)

5) Supportive mechanical ventilation

6) Temporary cardiac pacemaker on standby.

7) V/S every two hours for more than 12 hours

Patients who no longer require the intermediate level of nursing care may be transferred to Medical/Surgical Units.

WP\P&P\CCCTraDis.P&P

Revised June 1991

Reviewed/Revised Critical Care Complex Policy Meeting 6/92.

Humana Hospital
University of Louisville
POLICY PROCEDURE

No. -0420
Effective Date 8/1/84
Page 1 of 3

Subject:

TRANSFER OF PATIENTS FROM THE CRITICAL CARE COMPLEX TO ANOTHER FACILITY

PURPOSE:

To provide guidelines for the safe and efficient transfer of patients from the critical care complex to another facility.

To assure that all patients who have an emergency medical condition are transferred in accordance with the Cobra requirements.

POLICY STATEMENT:

All patients who transfer from the Critical Care Complex to another facility and who are considered to have an emergency medical condition, will be transferred in accordance with the requirements established by COBRA.

Transfers will be made using good medical practice and for the benefit of the patient. No patient will be transferred arbitrarily. Transfers will be made for medical, not economic, reasons.

Transfers can take place only after the transferring physician has received approval for transfer by the patient/ patients' family and the accepting physician.

The Critical Care Complex will secure a written, informed consent prior to transfer. This consent must include the risks and benefits of the transfer.

When transferring a patient to another facility, the following must accompany the patient:

1. copies of all medical records related to the emergency condition and available at the time of transfer;

2. Copy of the patient's request for transfer or the physician's transfer certification; and,

3. The name and address of any on-call physician who refused or failed to appear within a reasonable amount of time to provide necessary stabilizing treatment.

All patient requests for transfer must be in writing and must include a statement of the Hospital's obligations and the risks of transfer.

Social Service will be contacted prior to the transfer of any patient from the Critical Care Complex to another facility. Social Service will make the ambulance arrangements.

Air ambulance transfers are arranged through Social Service, using only authorized medical air transport services who supply the medical flight personnel and the equipment/supplies.

ACTOR

Physician

ACTION

1. Determines need for transfer (patient/family request or medical necessity) and arranges physician acceptance of the patient at the receiving facility.

2. Writes transfer order in the patient's medical record.

3. Completes transfer summary and signs, indicating the date and time.

4. Explains risks and benefits of transfer to patient/family and completes the physician section of the "Physician Certificate and Patient Request for Transfer" Form including:

   A. name of patient
   B. name of receiving facility
   C. name of receiving physician
   D. summary of risks
   E. summary of benefits

ACTOR

Physician/Registered Nurse

ACTION

5. If the patient/family is requesting the transfer, completes the patient request section form including:

   a. name of patient
   b. name of receiving facility
   c. mode of transportation

   d. risks of transfer
   e. physician's name who discussed risks/benefits

6. Obtains patient's or nearest of kin's signature on form, along with the relationship to the patient, a witnesses signature, the date, and the time.

7. Accompanies patient during transport to the receiving facility, as patient's condition indicates.

   NOTE: All patient's who are being transferred to the intensive care unit at the receiving facility will be accompanied by a physician or a Registered nurse.

ACTOR

Registered Nurse

ACTION

8. Completes appropriate sections of transfer summary.

9. Assures discharge planning is documented.

ACTOR

Unit Secretary/RN/LPN

ACTION

10. Notifies Social Service of plan to transfer patient.

11. Places patient's name, medical record number and unit/bed on all forms pertaining to the patient's transfer using the addressograph.

12. Places the yellow copy of the Physician Certificate and Patient Request for Transfer form, the transfer summary, a copy of the physician's discharge notes and copies of any other approved, requested chart information in an envelope with the patient's name on it for transfer to the receiving facility.

13. Gather's [sic] the patient's personal possessions for transfer.

14. Prepares for transport by gathering supplies/equipment needed.

ACTOR

Registered Nurse

ACTION

15. Telephones receiving registered nurse and reports patient's condition and nursing needs.

16. Completes Nurses Notes, including:

    a. transfer summary
    b. vital signs
    c. general condition on departure
    d. time of departure
    e. method of transport

ACTOR

Registered Nurse or Unit Secretary

ACTION

17. Enters any charges on computer.

18. Informs physician of arrival of ambulance if physician to accompany patient.

19. transfers patient.

WP\P&P\CCCTranAnoFac.P&P

Reviewed/Revised in the CCC Policy Meeting on June, 1992

Humana Hospital University
POLICY PROCEDURE

No. 768-0901
Effective Date 6/15/85
Page IX

Subject:

NURSING HOME PLACEMENT

POLICY:

Plans for Nursing Home Placement will be coordinated by Social Services with consultation and collaboration of the patient, his family and other medical disciplines.

PROCEDURE:

Actor:

Social Worker

Action:

1. Councils with patient, family and other "health care disciplines" regarding continuing care needs of the patient and the resources of the patient and family to meet these care needs (both physical and emotional).

   A.

   1. Home Health Care
   2. Nursing Home Placement

   A. The determination is made by the patient and family, that the care needs exceed their abilities and nursing home placement is requested.

2. Asks patient and family if they wish to suggest a licensed nursing facility that has the appropriate level of care needed.

3. Advises patient and family that the preferred facility will be contacted, but if there is no available bed, other licensed appropriate facilities will be contacted for admission.

Actor:

Physician

Action:

4. Documents the need for Nursing Home Placement.

5. Orders the following:

   A. Review for long term care

   B. CBC, CXR, VDRL, PPD

Actor:

Social Worker

Action:

6. Contacts appropriate facilities considering family request first and proximity. If the above facilities have no available bed, then other facilities are contacted until placement is found.

Actor:

Nursing/Physician

Action:

7. Assists Social Worker with nursing home placement as needed, relaying care needs to the worker and/or directly to the nursing home as requested.

Actor:

Social Worker

Action:

8. Notifies patient and family of accepting facility.

9. Advises patient and family of possible consequences if placement is refused.

Actor:

Patient/Family

Action:

10. Decide if they will accept the placement plan. If plan is refused, patient will be discharged in the care of himself and/or family.

Actor:

Social Worker

Action:

11. Communicates with physician and nursing, the discharge plan.

12. Makes referrals to a licensed certified home health agency if this is the decision of the family when placement is refused.

13. Refers patient to Adult Protective Services, if patient's discharge home appears to be a situation that may be harmful or neglectful.

Actor:

Patient/Family

Action:

14. Accept nursing home placement as agreed on.

Actor:

Social Worker

Action:

15. Asks physician for a tentative discharge date.

16. Informs family and receiving facility, the tentative discharge date.

17. Reports to nursing and physician, the date facility will accept patient.

Actor:

Physician

Action:

18. Dictates and signs a STAT discharge summary and completes physicians information part of Transfer Form.

Actor:

Social Worker

Action:

19. Completes Social Evaluation part of Transfer Form.

20. Makes appropriate transportation arrangements.

Actor:

Nursing

Action:

21. Completes Nursing Assessment of Transfer Form.

22. Checks to see if all requested medical papers are completed for transfer.

23. Prepares patient and his personal belongings for discharge.

Actor:

Social Worker

Action:

24. Sends appropriate paper work at time of transfer.

    a. History & Physical
    b. Chest x-ray
    c. VDRL
    d. CBC
    e. Signed Discharge Summary
    f. Transfer form
    g. PPD results
    h. Statement of emergency
    i. Decubitus cultures
    j. Open wound cultures

25. Make transportation arrangement as agreed upon by patient or family.

Humana Hospital
University of Louisville
POLICY PROCEDURE

No. 768-0912
Effective Date 7/10/91
Page 1

Subject:

REHABILITATION REFERRALS

POLICY:

Plans for Rehabilitation placement will be coordinated by Social Services with consultation and collaboration of the patient, family and medical personnel.

PROCEDURE:

Actor:

Physician

Action:

1. Documents the need for rehabilitation consultation.
2. Orders the following when needed:
   A. PPD, VDRL, cultures of trach sites, open wounds, sputum, etc.

Actor:

Social Worker

Action:

3. Monitors progress of patient for appropriateness of rehab consult.
4. Discusses rehab with physician if physician hasn't already ordered rehab consult.

5. Discusses rehab process with patient and/or family.
6. Reviews patient's insurance coverage and refers for medicaid if eligible.
7. Contacts appropriate rehab facilities and/or contacts a physiatrist group to perform rehab evaluation.
8. Follows-up with rehab facilities to determine their acceptance or denial of patient.
9. Notifies family of which facilities are an option for patient.

Actor:

Patient/Family

Action:

10. Reviews options available and decides on a rehab facility.
11. Notifies social worker of their decision.
12. Fills out appropriate paperwork for the accepting facility.

Actor:

Physician

Action:

13. Notifies social worker of readiness for rehab transfer.
14. Dictates stat discharge summary and completes transfer form.

Actor:

Social Worker

Action:

15. Checks bed availability and arranges a time for transfer.

Actor:

Nurse

Action:

16. Assists with paperwork, completes nursing assessment on transfer form.

17. Calls report to accepting facility's nurse.

Actor:

Social Worker

Action:

18. Sends appropriate paperwork:

    A. H&P
    B. Culture reports
    C. Physical Therapy notes
    D. Speech notes (if appropriate)
    E. CT Scans (if needed)
    F. D/C Summary
    G. Transfer form

19. Notifies patient/family of plans for transfer.

20. Calls ambulance for transport.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE
CIVIL ACTION NO. C-93-0544L(CS)

[Caption Omitted In Printing]

* * *

DEPOSITION FOR PLAINTIFF

* * *

TRANSCRIPT OF DEPOSITION OF NANCY FRED, TAKEN, PURSUANT TO NOTICE, ON MONDAY, NOVEMBER, 22, 1993, AT 1:30 P.M., * * *

* * *

[p. 25] A. (READING.) "SPOKE WITH PATIENT'S AUNT, JANE ROBERTS, WHO IS UNABLE TO LOCATE PATIENT'S HUSBAND. HAVE FOLLOWED HIS INSTRUCTIONS AND PAGED HIM REPEATEDLY WITHOUT EFFECT. HAVE LOCATED NURSING HOME IN CHANDLER, INDIANA. THAT HAS CLINICALLY ACCEPTED PATIENT, PENDING THEIR COUNCIL ON AGING'S OKAY. WILL KNOW TODAY. HAVE INFORMED PATIENT'S MOTHER AND AUNT WE MAY TRANSFER PATIENT TO CHANDLER NURSING HOME IN NEXT DAY OR TWO. NEW MEDICO ALSO STILL INVOLVED; PREDICT APPROVAL WILL TAKE ANOTHER ONE TO TWO WEEKS."

Q. NOW, HAVE YOU EVER REFERRED A PATIENT TO THIS CHANDLER, INDIANA, NURSING FACILITY PRIOR TO THIS?

A. YES.

Q. SO YOU WERE FAMILIAR WITH THEIR FACILITY AND WHAT THEY HAD TO OFFER.

A. RIGHT, YES.

Q. AND HOW DID YOU COME INTO CONTACTING THEM OR REFERRING THEM TO HER? APPARENTLY, IT WASN'T ON YOUR FIRST LINE OF REFERRALS.

A. WELL, EVIDENTLY, SHE'S BEEN WEANED, YOU KNOW, FROM THE VENTILATOR, AND THAT MEANS THAT OTHER NURSING HOMES COULD HANDLE HER CARE. NOW, I CAN'T, I'M JUST SURE THAT HANOVER OBVIOUSLY COULDN'T TAKE HER ONE WAY OR THE OTHER AT THIS POINT, OR WE WOULD HAVE PROCEEDED WITH HANOVER. SINCE THAT WE KNEW, AS OF, YOU KNOW, THE INITIAL CONTACT WITH THE HUSBAND, WAS AN OKAY DISTANCE, AND YOU KNOW, FOR HIM AND [p. 26] EVERYTHING. SO I MEAN, IT JUST GOES WITHOUT SAYING, I MEAN, TO ME, MAYBE NOT TO YOU, THAT HANOVER WAS NOT AVAILABLE AT THIS POINT, AND NONE OF THE OTHER VENTILATOR-DEPENDENT NURSING HOMES HAD RESPONDED THAT THEY COULD TAKE HER AT THIS POINT.

Q. OKAY.

A. BUT THE PROBLEM WITH CHANDLER IS IT'S, YOU KNOW, IT WAS A LITTLE FARTHER, YOU KNOW, AND I'M SURE LESS DESIRABLE FOR PATIENTS IN LOUISVILLE AND FURTHER SOUTH.

Q. WHERE IS CHANDLER, INDIANA?

A. IT'S A SUBURB OF EVANSVILLE.

Q. LET'S GO TO THE NEXT DAY, WHICH IS JULY 21ST, AND "EXHIBIT G."

A. (READING.) AS OF THIS A.M., CHANDLER NURSING HOME IS PLANNING TO ADMIT PATIENT ON THE 22ND. THEY DO NEED TO OBTAIN PRIOR OKAY FROM THEIR COUNTY'S COUNCIL ON AGING THIS A.M. AWAIT FINAL DECISION. WILL NEED SIGNED EMERGENCY NURSING HOME ADMISSION, TRANSFER FORMS, INCLUDING ORDERS FROM PHYSICAL THERAPY AND SPEECH THERAPY. WILL NEED STAT D/C SUMMARY AND D/C ORDERS.

Q. ALL RIGHT. SO AT THIS POINT, IT LOOKS LIKE SHE'S GOING TO BE TRANSFERRED TO CHANDLER.

A. YES.

Q. LET'S GO TO THE NEXT DAY, WELL, ACTUALLY THE SAME DAY, ON "EXHIBIT H."

[p. 27] A. (READING.) "CHANDLER NURSING HOME HAS ACCEPTED PATIENT. COUNCIL ON AGING HAS OKAYED TRANSFER. PATIENT TO BE TRANSFERRED 7-22, HOPEFULLY BY 11 A.M. PATIENT'S HUSBAND WAS INFORMED AND AGREES. PATIENT INFORMED. PLEASE SIGN EMERGENCY NURSING HOME ADMISSION NOTE AND COMPLETE TRANSFER FORM. FRONT OF CHART AND DICTATE STAT D/C SUMMARY BY 9:30 TO 10 A.M.

Q. IT STILL LOOKS LIKE CHANDLER IS THE PLACEMENT AT THIS POINT, CORRECT?

A. YES.

Q. ON JULY 21ST, IT STILL APPEARED THAT CHANDLER NURSING HOME WAS THE PLACEMENT.

A. YES.

Q. IT SAYS "PATIENT INFORMED." WAS WANDA'S CONDITION SUCH AT THAT TIME THAT SHE WOULD HAVE UNDERSTOOD THAT? WHAT WOULD THAT MEAN?

A. YOU DIDN'T KNOW; YOU JUST DIDN'T KNOW. SHE, IT WAS THOUGHT THAT MAYBE NEUROLOGICALLY, SHE WAS STARTING TO UNDERSTAND A LITTLE BIT. IT WAS INCONSISTENT, AND SO –

Q. STILL COULDN'T TALK AT THIS POINT, CORRECT?

A. COULDN'T COMMUNICATE.

Q. STILL COULDN'T MOVE, I SUPPOSE.

A. HEAD NODS WERE INCONSISTENT, BUT SOMETIMES FORTHCOMING.

Q. SO THIS INDICATES THAT YOU TOLD HER –

[p. 28] A. TRIED, TRIED TO COMMUNICATE –

Q. SO IT INDICATES YOU ADVISED THE PATIENT. DO YOU HAVE ANY WAY OF KNOWING WHETHER SHE UNDERSTOOD THAT SHE HAD BEEN ADVISED SHE WAS BEING TRANSFERRED TO CHANDLER AT THIS POINT?

A. NOT REALLY.

Q. LET'S GO AHEAD TO THE NEXT DAY, WHICH WAS JULY 22ND, AND I BELIEVE "EXHIBIT I."

A. (READING.) "CHANDLER NURSING HOME DIRECTOR OF NURSING WILL SEE PATIENT AT OUR FACILITY PRIOR TO HER TRANSFER TODAY TO ASSESS ALL POSSIBLE TREATMENT NEEDS AND SEE THAT NECESSARY STAFF AND EQUIPMENT ARE IN PLACE. HAVE COPIED CHART TO SEND WITH PATIENT. WILL ORDER AMBULANCE AFTER CHANDLER DIRECTOR OF NURSING SEES PATIENT. PATIENT WILL BE PLACED AT SKILLED LEVEL."

Q. ALL RIGHT. NEXT PAGE, THE SAME DAY, I THINK IT'S "J." WOULD YOU READ THAT?

A. (READING.) "CHANDLER HEALTH CARE HAS NOW RECANTED PRIOR DECISION TO ACCEPT PATIENT. SOCIAL SERVICES DIRECTOR, GOLDIE MURPHY, HAS SPOKEN WITH CHANDLER'S ADMINISTRATOR. AND WE EXPECT FINAL DECISION THIS P.M. IN INTERIM, HAVE ASKED MAYFAIR NURSING HOME, INDIANAPOLIS, TO EVALUATE PATIENT. THEY DID SO THIS P.M. WILL ALSO HAVE SOUTHSIDE NURSING HOME, INDIANAPOLIS, EVALUATE PATIENT TOMORROW, IF NECESSARY. NEW MEDICO HEAD INJURY IS ALSO STILL INVOLVED. THEIR DECI- [p. 29] SION PROCESS TAKES LONGER, AND NO FINAL DECISION IS POSSIBLE FROM THEM FOR AT LEAST ANOTHER WEEK. ALSO, NEW MEDICO WOULD REQUIRE "G" TUBE, "G" OR "J" TUBE."

Q. ALL RIGHT. DO YOU HAVE ANY IDEA WHY CHANDLER HEALTH CARE RECANTED THEIR DECISION TO ACCEPT WANDA?

A. NO, I DON'T.

Q. THEY DIDN'T TELL YOU WHY THEY WEREN'T GOING TO TAKE HER?

A. THEY JUST SAID THEY DIDN'T THINK THAT THEY COULD MEET HER CARE NEEDS AT THAT TIME.

Q. WAS THIS THE DIRECTOR OF NURSING WHO YOU HAD REFERRED TO WAS GOING TO MAKE THE EVALUATION?

A. YES.

Q. AND DID THAT CONVERSATION BETWEEN YOU AND THAT DIRECTOR OF NURSING TAKE PLACE AFTER THE EVALUATION WAS DONE THAT DAY?

A. THE EVALUATION WAS DONE. AND I THINK THEN, SHE PROBABLY WENT BACK AND CONSULTED WITH, YOU KNOW, HER STAFF.

Q. DO YOU REMEMBER, DID SHE CALL YOU AND TELL YOU THIS, OR DID YOU SPEAK WITH HER AT THE HOSPITAL HERE IN LOUISVILLE?

A. I THINK THEY WERE AT THE HOSPITAL. THEY WERE FREQUENTLY AT THE HOSPITAL, CHANDLER, THE ADMINISTRATOR AND HIS DIRECTOR OF NURSING.

Q. AFTER CHANDLER HAD RECANTED AND DETERMINED THAT [p. 30] THEY COULDN'T MEET HER CARE NEEDS, AT THAT POINT, WERE YOU ABLE TO CONTACT ANY OF WANDA'S FAMILY TO ADVISE THEM THAT CHANDLER WAS NO LONGER IN THE PICTURE?

A. I JUST DON'T REMEMBER THE SPECIFICS OF WHAT HAPPENED WHEN. I KEPT FAMILY MEMBERS, YOU KNOW, APPRISED ALWAYS, YOU KNOW, OF THE PROGRESS OF THE PLAN AND ANY CHANGES THAT OCCURRED. I MEAN, I DON'T HAVE A NOTE HERE.

Q. SO YOU FEEL LIKE YOU DID AT SOME POINT TELL ONE OF THE FAMILY MEMBERS THAT CHANDLER WAS NO LONGER WILLING TO TAKE WANDA.

A. YES, AND IT MIGHT HAVE BEEN WHEN I, YOU KNOW, WHEN I HAD FOUND A NURSING HOME THAT WOULD, SINCE IT ALL CAME SO CLOSE TOGETHER HERE.

Q. LET'S GO TO THE NEXT DAY, WHICH IS JULY THE 23RD, AND OUR "EXHIBIT K", AND ASK YOU TO REVIEW THOSE NOTES. PLEASE.

A. (READING.) "CHANDLER NURSING HOME HAS OFFICIALLY REJECTED PATIENT; MAYFAIR NURSING HOME, INDIANAPOLIS, HAS EVALUATED PATIENT AT OUR FACILITY 7-22, AND SOUTHSIDE NURSING HOME, INDIANAPOLIS, WILL EVALUATE PATIENT TODAY. SHOULD HAVE RESPONSE LATE 7-23 OR EARLY 7-24. NEW MEDICO REHAB ALSO STILL FOLLOWING BUT REQUIRES "G" OR "J" TUBE."

Q. ALL RIGHT, AND THEN THE LAST PAGE OF THAT, WHICH I BELIEVE IS JULY 24, AND "EXHIBIT L." WOULD YOU REVIEW THAT, PLEASE?

[p. 31] A. (READING.) "PATIENT TO BE TRANSFERRED TO CRESTVIEW HEALTH CARE, INDIANAPOLIS, TODAY AT 2:30 P.M. HAVE NOTIFIED

PATIENT'S AUNT, JANE ROBERTS. UNABLE TO CONTACT PATIENT'S HUSBAND. WILL SEND LETTER WITH SPECIFIC DISCHARGE INFORMATION TO MR. JOHNSON. CHART COPIED TO SEND. COMMONWEALTH ACLS AMBULANCE TO TRANSPORT PATIENT AT 2:30 P.M."

Q. OKAY, MS. FRED, CRESTVIEW HEALTH CARE FACILITY, THAT'S REFERRED TO FOR THE FIRST TIME ON JULY 24, WHAT DID YOU KNOW ABOUT THAT FACILITY PRIOR TO JULY 24 OF 1992?

A. JULY 22ND, CAN I REFER BACK HERE, BECAUSE –

Q. CERTAINLY.

A. – CRESTVIEW AND MAYFAIR ARE PART OF THE SAME CHAIN, RUN BY THE SAME MANAGEMENT. OKAY, ON 7-22, MY NOTE SAYS, IN INTERIM, HAVE ASKED MAYFAIR NURSING HOME, INDIANAPOLIS, TO EVALUATE PATIENT. THEY DID SO THIS P.M. SO THE PERSON WHO WAS THERE, WHO EVALUATED THE PATIENT, WHO REPRESENTED MAYFAIR, ALSO REPRESENTED CRESTVIEW, AND SHE, JOANNA NOLTE, GAVE US A LITTLE IN-SERVICE ON HER HOSPITAL, PROVIDED SOME LITERATURE ABOUT WHAT CAPABILITIES THEY HAD, THERAPIES, AND EVALUATED THE PATIENT AT THAT TIME.

Q. NOW, WHEN SHE PROVIDED THAT INFORMATION TO YOU, WAS THAT INFORMATION RELATIVE TO MAYFAIR OR TO CRESTVIEW, OR DO YOU RECALL?

A. ALL OF, I THINK THEY HAD LIKE SIX DIFFERENT NURSING HOMES ALL IN THE INDIANAPOLIS AREA, SO SHE TALKED ABOUT [p. 32] THEIR WHOLE PROGRAM, MAYBE INDIVIDUALIZED A LITTLE BIT, YOU KNOW, AS SOME OF THE NURSING HOMES MIGHT SPECIALIZE IN, I DON'T KNOW, CLOSED UNIT FOR ALZHEIMER'S OR SOMETHING LIKE THAT.

Q. DO YOU RECALL SPECIFICALLY WHAT SHE MAY HAVE TOLD YOU THAT CRESTVIEW OFFERED PATIENTS?

A. NO.

Q. HAD YOU, PRIOR TO THIS TIME, HAD ANY EXPERIENCE REFERRING PATIENTS TO MAYFAIR OR CRESTVIEW OR ANY ONE OF THAT NATURE?

A. NO.

Q. HOW DID YOU FIRST LEARN THAT THIS HOSPITAL OR THIS NURSING HOME GROUP WAS INTERESTED IN ACCEPTING TRANSFERS FROM THE HOSPITAL?

A. JOANNA AND SOMEONE ELSE FROM HER ORGANIZATION, I BELIEVE, CAME DOWN TO US WITH THAT INTENTION, TO COMMUNICATE THAT THEY HAD SIX NURSING HOMES, AND THEY HAD AVAILABLE BEDS, AND THEY HAD SERVICES TO PROVIDE ON THE 22ND.

Q. OKAY, SO ON JULY 22ND, THEY CAME TO THE HOSPITAL TO RECRUIT OR, I GUESS, TO DISCUSS WITH THE HOSPITAL THE AVAILABILITY OF THEIR FACILITY.

A. THAT'S RIGHT, YES.

Q. AND THAT WAS THE FIRST TIME THAT YOU HAD EVER HEARD OF THIS FACILITY? WAS THAT THE FIRST TIME?

A. I THINK SO, YOU KNOW; THAT'S NOT, I MEAN, I DON'T [p. 33] REMEMBER EXACTLY.

Q. WERE THERE OTHER PEOPLE WHO ATTENDED THIS CONFERENCE WITH YOU WITH JOANNA NOLTE WHEN SHE DISCUSSED WHAT THEIR FACILITY HAD TO OFFER?

A. RIGHT, THE OTHER SOCIAL WORKERS, THE OTHER DISCHARGE PLANNERS AND THE DIRECTOR.

Q. ALL RIGHT, SO THERE WERE SEVERAL OF YOU THAT THEY PUT ON A PRESENTATION TO APPARENTLY.

A. YES.

Q. AND THIS WAS ALL ON JULY 22ND.

A. YES.

Q. AND WAS JOANNA NOLTE SCHEDULED TO EVALUATE PATIENTS THAT DAY? HAD YOU, PRIOR TO THIS, SCHEDULED WITH HER EVALUATIONS OF VARIOUS PATIENTS AT THE HOSPITAL?

A. NO.

Q. ALL RIGHT. SO AFTER, TELL US HOW SHE CAME TO PERFORM THESE EVALUATIONS THAT DAY.

A. SHE ASKED US, AS A GROUP, YOU KNOW, AFTER HER PRESENTATION, IF WE HAD, IF THERE

WERE ANY PATIENTS THAT SHE COULD EVALUATE WHILE SHE WAS HERE ON SITE, SO –

Q. AND DO YOU REMEMBER –

A. – SEVERAL OF US, I'M SURE.

Q. OKAY. DO YOU REMEMBER HOW MANY PATIENTS THAT SHE EVALUATED THAT DAY?

A. NO.

[p. 34] Q. DID SHE EVALUATE MORE OR JUST ONE?

A. JUST ONE, YES.

Q. SHE EVALUATED ONLY ONE OF YOUR PATIENTS THAT DAY, I TAKE IT.

A. YES, JUST ONE.

Q. AND THAT PATIENT WAS WANDA JOHNSON.

A. YES.

Q. NOW, DO YOU HAVE ANY INFORMATION AS TO WHETHER THE HOSPITAL OR ANY OF THE OTHER SOCIAL WORKERS HAD EVER REFERRED PATIENTS TO MAYFAIR OR CRESTVIEW NURSING HOMES PRIOR TO THIS?

A. I REALLY DON'T KNOW. NONE OF US HAD WORKED WITH JOANNA BEFORE. THAT DOESN'T MEAN ONE OF US HADN'T WORKED WITH ONE OF THOSE NURSING HOMES. IN FACT, IT'S LIKELY THAT SOMEONE HAD, BUT NO ONE HAD WORKED WITH THIS MANAGEMENT TEAM. WE, YOU KNOW, WE DON'T ALWAYS KNOW WHAT NURSING HOMES THE

OTHER WORKERS ARE WORKING WITH, NOT ALWAYS.

Q. NOW, WHEN JOANNA NOLTE CAME TO THE HOSPITAL ON JULY 22ND AND GAVE YOUR STAFF THIS PRESENTATION, WAS THIS SOMETHING THAT HAD BEEN SET UP PRIOR TO THE 22ND? HAD SHE CALLED AND MADE AN APPOINTMENT TO DO THIS, OR DO YOU KNOW?

A. I FEEL, I DON'T KNOW FOR SURE, BUT I FEEL THAT'S THE WAY IT'S USUALLY HAPPENED.

Q. AND WHO WOULD SHE HAVE CALLED TO MAKE THOSE ARRANGEMENTS?

* * *

[p. 36] OTHER NURSING HOMES IN THAT CHAIN WILL STILL ACCEPT TRANSFERS FROM YOUR HOSPITAL?

A. WELL, THEY DID. THEY DID THROUGHOUT THE NEXT 12 MONTHS, I KNOW. I WOULD ASSUME THEY WOULD.

Q. MS. FRED, YOU INDICATED EARLIER IN THE DEPOSITION THAT PART OF YOUR RESPONSIBILITY AS A SOCIAL WORKER WAS TO MAKE PLACEMENT REFERRALS FOR PATIENTS WHO COULDN'T RETURN HOME, AND THAT PART OF THAT WAS TO INQUIRE INTO AND SEE THAT THE REFERRAL SITES THAT YOU MAKE CAN PROVIDE THE MEDICAL CARE OR TRAINING OR MEDICAL CARE OR REHABILITATION SERVICES THAT THESE PATIENTS REQUIRE. WHAT INQUIRY DID YOU MAKE WITH MRS. NOLTE ABOUT

WHAT CRESTVIEW COULD PROVIDE FOR WANDA JOHNSON? WHAT INQUIRY WAS MADE THERE?

A. SHE, YOU KNOW, SHE COMMUNICATED INFORMATION ABOUT THE PROGRAM THAT INDICATED IT WAS A SKILLED NURSING FACILITY, CERTIFIED BY THE STATE CERTIFICATION AGENCY; THAT THEY HAD THE THERAPIES THAT MRS. JOHNSON COULD BENEFIT FROM TO WORK TOWARD HER REHABILITATION.

Q. DO YOU RECALL SPECIFICALLY WHAT KIND OF REHABILITATION OR WHAT KIND OF THERAPIES MRS. JOHNSON WAS GOING TO BE DISCHARGED IN NEED OF AT THAT TIME?

A. YEAH, AS A HEAD INJURY, COGNITIVELY IMPAIRED, SHE WOULD NEED SPEECH THERAPY, PHYSICAL THERAPY, OF COURSE, OCCUPATIONAL THERAPY.

BY MR. THOMPSON: SHE WAS GIVING YOU A LIST, [p. 37] WHEN YOU ASKED HER, WHEN YOU ASKED THE FOLLOW-UP QUESTION, AND –

Q. OKAY.

BY MR. THOMPSON: – I DON'T MIND IF YOU GO ON, BUT I JUST WANT TO –

Q. OKAY. YOU'VE GIVEN ME A LIST OF THREE TYPES OF THERAPIES THAT MRS. JOHNSON NEEDED AT THE POINT OF HER DISCHARGE.

BY MR. THOMPSON: I'M SORRY, SHE HAD GIVEN YOU A LIST OF WHAT INQUIRIES SHE HAD MADE.

Q. OKAY.

BY MR. THOMPSON: I THINK SHE WAS, THE LAST ONE SHE GAVE YOU WAS, IN THE HEAD THERAPY, SHE WAS IN NEED OF, I THINK SHE WAS GETTING READY TO CONTINUE WHEN YOU ASKED HER THAT.

Q. OKAY. ALL RIGHT, LET ME MAKE SURE I UNDERSTAND YOU. THIS LIST OF THERAPIES, SPEECH, PHYSICAL AND OCCUPATIONAL THERAPIES, DID YOU INQUIRE OF JOANNA NOLTE SPECIFICALLY AS TO WHETHER OR NOT HER NURSING HOMES COULD PROVIDE THESE SERVICES TO WANDA JOHNSON?

A. YES.

Q. YOU DID.

A. YES.

Q. AND DID SHE ADVISE YOU THAT THEY COULD DO THAT?

A. YES.

[p. 38] Q. DO YOU –

A. ALSO, I'M SORRY –

Q. GO AHEAD.

A. – SPIRATORY.

Q. NOW, DID SHE SAY THAT THEY COULD DO THESE AT MAYFAIR OR CRESTVIEW, OR DID SHE SAY SPECIFICALLY WHICH NURSING HOMES SHE WAS SPEAKING OF?

A. WHEN WE ORIGINALLY TALKED, WHEN SHE EVALUATED MRS. JOHNSON IN THE UNIT AND LOOKED AT THE CHART, SHE WAS WORKING TOWARD MAYFAIR. WHEN SHE COMMUNICATED THE DECISION THAT THE TEAM HAD DECIDED THAT WANDA'S NEEDS COULD BEST BE MET AT CRESTVIEW, SHE INDICATED THAT THEY HAD THE NECESSARY MODALITIES AS WELL.

Q. DID JOANNA NOLTE EVER TELL YOU THAT WANDA JOHNSON'S NEEDS EXCEEDED HER AUTHORITY TO AUTHORIZE TRANSFER OR ACCEPTANCE AT HER NURSING HOME?

A. NO.

Q. SHE DIDN'T TELL YOU THAT.

A. OH, NO.

Q. IS THERE ANYONE ELSE THAT YOU SPOKE WITH AT CRESTVIEW OR MAYFAIR OR THE PARENT COMPANY ABOUT WANDA JOHNSON'S REFERRAL TO THEIR FACILITY?

A. IN THE COURSE OF THE NEXT TWO DAYS, BETWEEN THE EVALUATION THAT SHE MADE AND THE TIME THAT WANDA WAS DISCHARGED, I HAD SPOKEN SEVERAL TIMES WITH RANDY GROSS, WHO

* * *

[p. 41] A. YES.

Q. DO YOU REMEMBER, WAS THAT PHONE CALL THE DAY OF, DO YOU REMEMBER WHEN THAT PHONE CALL TOOK PLACE?

A. I DON'T. I'M SURE I DIDN'T TALK TO HIM ON THE 22ND. I'M SURE I TALKED TO HIM ON THE 23RD AND PROBABLY ON THE 24TH AS WELL.

Q. DO YOU REMEMBER WHAT THE SUBSTANCE OF THOSE CONVERSATIONS WAS?

A. NO.

Q. WHEN DID YOU FIRST ADVISE ANY OF THE FAMILY MEMBERS, ANY OF WANDA'S FAMILY MEMBERS, OF HER TRANSFER TO CRESTVIEW?

A. WELL, SINCE I DIDN'T REALLY KNOW FOR SURE UNTIL THE 23RD, IT COULDN'T HAVE BEEN BEFORE THEN, SO IT WAS THE 23RD AND/OR THE 24TH.

Q. SO YOU SAY YOU TALKED TO SOMEBODY ON THE 23RD AND ON THE 24TH.

A. AND/OR.

Q. ALL RIGHT. DO YOU KNOW WHO YOU TALKED TO?

A. YEAH, IT WAS THE AUNT, JANE ROBERTS.

Q. AND YOU SPOKE WITH HER PRIOR TO HER BEING TRANSFERRED?

A. YES.

Q. DID YOU EVER ATTEMPT TO GET A-HOLD OF WANDA'S MOTHER OR HER HUSBAND?

[p. 42] A. I HAD, YEAH; I TRIED DAILY OR AT ANY TIME A DECISION POINT WAS REACHED TO GET IN TOUCH WITH MR. JOHNSON. YOU KNOW,

THIS WAS REAL IMPORTANT. YOU KNOW, TO TRY TO REACH THE NEXT OF KIN. I WAS CONCERNED ABOUT IT, AND I DID TRY, BUT THE AUNT HAD BEEN THE MOST HELPFUL OF THE FAMILY MEMBERS' THAT OFFERED THE MOST INFORMATION. WANDA'S MOTHER DIDN'T SEEM TO WANT TO BE INVOLVED IN ANY DECISIONS.

Q. DO YOU FEEL LIKE WANDA'S AUNT HAD AUTHORITY TO AUTHORIZE A TRANSFER TO INDIANAPOLIS?

A. SHE WAS THE FAMILY MEMBER THAT WE WERE IN COMMUNICATION WITH. AND EVERYBODY ELSE HAD ABSCONDED OR ELIMINATED THEMSELVES.

Q. WHEN YOU SPOKE WITH THE AUNT, DO YOU REMEMBER WHAT SHE SAID OR ANY COMMENTS THAT SHE MAY HAVE MADE CONCERNING THE TRANSFER WERE WHEN YOU ADVISED HER OF THIS MAYFAIR/CRESTVIEW DECISION?

A. WE HAD BEEN IN COMMUNICATION CONTINUOUS FROM THE TIME, YOU KNOW, THAT I FIRST REACHED HER. I HAD, YOU KNOW, IT'S AN EDUCATED PROCESS WITH FAMILY MEMBERS, WHEN YOU'RE INVOLVED IN THE PLACEMENT OF A PATIENT, AND YOU CAN'T PUT THEM IN THEIR BACK YARD. IT'S IMPOSSIBLE AND SO, YOU KNOW, YOU'RE CONSTANTLY TRYING TO EDUCATE THEM TO WHAT THE PROBLEM IS AND THE LIMITATIONS OF THE SYSTEMS, AND YOU KNOW, WHY CHANDLER, EVANSVILLE AND, YOU KNOW. I'M SURE SHE EXPRESSED REGRET AT THE DISTANCE,

AND I EXPRESSED REGRET ALSO, AND SHE [p. 43] MAY HAVE, SHE PROBABLY SAID, WHAT ABOUT FEDERAL HILL OR, YOU KNOW, AND I'M SURE I SAID, I'LL CALL THEM. I KNOW THEY DON'T HAVE ANY BEDS, BECAUSE WE'VE SURVEYED REGULARLY, AND THESE THINGS ARE THINGS I DON'T SPECIFICALLY REMEMBER, BUT I'M SURE I WOULD HAVE ENCOURAGED HER TO PUT HER ON ANY LISTS, YOU KNOW, CLOSE AT HAND.

Q. DID SHE HAVE AN OPTION AT THAT POINT? HAD MRS. ROBERTS, HER AUNT, TOLD YOU, YOU KNOW, WE'RE NOT GOING TO GO ALL THE WAY TO INDIANAPOLIS; FIND SOME PLACE ELSE.

A. SHE DID, AND SHE DID NOT SAY THAT.

Q. HAD SHE SAID THAT, WHAT WAS THE HOSPITAL'S POSITION?

A. WELL –

BY MR. THOMPSON: LET ME OBJECT TO THE QUESTION. I THINK IT'S KIND OF SPECULATIVE. BUT GO AHEAD AND ANSWER IT.

A. WELL, AS THE ONLY FAMILY MEMBER LEFT THAT WE COULD CONTACT, THE PERSON THAT WE WERE WORKING WITH, IF SHE HAD SAID, I OPPOSE THIS, WE WOULDN'T HAVE DISCHARGED HER TO THAT FACILITY.

Q. JUST A COUPLE OF MORE QUESTIONS, AND WE'LL TAKE A BREAK. YOU HAD BEEN WORKING WITH NEW MEDICO –

A. YES.

Q. – THROUGHOUT THIS PROCESS, TRYING TO GET SOMETHING WORKED OUT WITH THEM. COULD YOU TELL US WHY YOU DIDN'T WAIT

* * *

[p. 54] Q. SO YOU'RE SAYING THAT –

A. I MEAN. THAT'S, YOU KNOW, I'M NOT A DOCTOR.

Q. ALL RIGHT, SO YOU'RE SAYING THAT FOR WANDA TO HAVE STAYED IN AN ACUTE SITUATION WOULD HAVE CONSTITUTED SOME TYPE OF RISK TO HER?

A. WELL, THE DOCTORS DETERMINE WHEN A PATIENT IS READY FOR DISCHARGE, YOU KNOW, AND THEY SAID SHE WAS.

Q. WHO DID YOU CONSULT WITH? YOU INDICATED THAT THE DECISION WAS NOT ALWAYS YOURS AS TO WHERE A PLACEMENT IS MADE, AS BETWEEN REHAB AND A NURSING HOME. BETWEEN THE 22ND OF JULY WHEN YOU MET WITH JOANNA NOLTE, AND THE 24TH WHEN WANDA WAS TRANSFERRED, DO YOU REMEMBER, DID YOU CONSULT WITH ANYONE ELSE ON THE STAFF ABOUT WHAT WERE WANDA'S OPTIONS AND WHERE WAS THE MOST APPROPRIATE TRANSFER?

A. PROBABLY, I'M SURE I DID. I'M SURE I DISCUSSED IT WITH MY DIRECTOR.

Q. WHO WOULD THAT HAVE BEEN?

A. GOLDIE MURPHY.

Q. ANYONE ELSE THAT YOU THINK YOU MAY HAVE CONSULTED WITH DURING THAT TIME?

A. JUST SHARING WITH COLLEAGUES.

Q. WOULD THERE HAVE BEEN ANY CONSULTATION AT ALL WITH ANY OF THE MEDICAL STAFF ABOUT, HERE'S WHAT WE'VE GOT TO OFFER THIS PATIENT; WE'VE GOT CRESTVIEW ON THE ONE HAND, AND WE'VE GOT NEW MEDICO, WHO STILL HASN'T AUTHORIZED THE TRANS- [p. 55] FER? ANY CONSULTATION AT ALL WITH ANYBODY ON THE MEDICAL STAFF DURING THAT PERIOD OF TIME?

A. I'M SURE I WAS SPEAKING WITH THE DOCTORS.

Q. AND WHICH DOCTORS WOULD THAT HAVE BEEN?

A. OH, PROBABLY DR. ABOU JAOUDE.

Q. IS HE STILL WITH THE HOSPITAL?

A. I BELIEVE HE IS.

Q. AND YOU BELIEVE YOU DISCUSSED WITH HIM –

A. YES.

Q. – YOUR TRANSFER STATUS?

A. HE AGREED WITH IT, YOU KNOW, FROM THE INFORMATION THAT HE HAD AND FROM, I DON'T KNOW IF DR. A. J. TALKED WITH JOANNA WHEN SHE WAS THERE. I DON'T REMEMBER.

Q. BUT YOU THINK THAT YOU DID TALK TO THE DOCTOR BETWEEN THE 22ND AND THE 24TH

AND ADVISED HIM OF THIS PROSPECTIVE TRANSFER.

A. YES.

Q. WHAT DID YOU KNOW ABOUT WANDA'S PAY STATUS, AS OF JULY 24?

A. I KNEW THAT SHE WAS WITHOUT INSURANCE, INDIGENT, MEDICALLY INDIGENT, AND THAT HER HUSBAND HAD APPLIED FOR SOCIAL SECURITY DISABILITY, WHICH ALSO INCLUDED A KENTUCKY MEDICAID APPLICATION.

Q. AT THAT POINT, YOU STILL DID NOT KNOW WHETHER OR NOT SHE'D BEEN APPROVED FROM KENTUCKY MEDICAID?

[p. 56] A. DID NOT.

Q. DO YOU HAVE, THE SOCIAL WORKER STAFF HAVE, I GUESS, DISCHARGE STANDARDS, SOMETHING THAT YOU LOOK AT TO SAY, HERE'S WHAT YOU LOOK TO TO DECIDE WHETHER A PATIENT IS APPROPRIATE FOR TRANSFER, OR THIS IS THE KIND OF TRANSFER, THE KIND OF REFERRAL THAT YOU MAKE ON A PARTICULAR KIND OF PATIENT? ARE THERE ANY KIND OF STANDARDS LIKE THAT THAT YOU HAVE THAT YOU GO BY?

A. I'M NOT SURE WHAT YOU MEAN. THERE ARE POLICIES AND PROCEDURES.

Q. EXACTLY, ARE THERE POLICIES AND PROCEDURES THAT YOU USE TO DETERMINE WHAT KIND OF PLACEMENT THAT YOU MAKE ON DISCHARGED PATIENTS?

A. WELL, I DON'T UNDERSTAND YOUR QUESTION. I'M SORRY.

Q. DO YOU HAVE A POLICY MANUAL AT THE HOSPITAL THAT EXPLAINS THE FACTORS THAT YOU CONSIDER WHEN DECIDING WHICH OF VARIOUS ALTERNATIVES, IN DISCHARGE PLACEMENTS, THAT YOU SHOULD MAKE ON A GIVEN PATIENT?

A. YOU KNOW, IT'S BEEN SO LONG SINCE I'VE LOOKED AT THEM, I'M NOT SURE. I'M SURE, YES.

Q. THAT YOU THINK THOSE POLICIES EXIST.

A. AND MANY OF THE POLICIES ARE COMMON SENSE, OR THEY'RE STATE-REGULATED. FOR EXAMPLE, YOU CAN'T SEND A PATIENT WHO NEEDS INTERMEDIATE CARE TO A PERSONAL CARE PLACEMENT. THAT'S A VIOLATION OF THE STATE CERTIFICATIONS.

* * *

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CAUSE NO. C-93-0544L-M

[Caption Omitted In Printing]

The video deposition upon oral examination of JO ANNA NOLTE, * * * on the 24th day of January, 1994, * * *

* * *

[p. 22] June or July of 1992 in your visit to the University Hospitals, University of Louisville staff, tell us what happened, what – what did you do on that first visit?

A I met with them as a group and there were quite a few social workers there, maybe eight to ten of the social workers were there. I spoke to them about our different facilities; of course, introduced myself. I took them lit – any literature at that time.

Q What type of literature did you usually have?

A Brochure and – and my business cards and that was all we had.

Q One brochure?

A I took I believe several down so that they'd have some.

Q But there – there was one – one brochure –

A For the entire –

Q – that you brought several copies of?

A Right, and there was one brochure for the company that was used for all – all the facilities.

Q How many different types of brochures did you bring to – to Louisville?

[p. 23] A We had only one type of brochure to bring.

Q So your initial contact was when you came to Louisville and you had a meeting with several of the social workers?

A Uh-huh.

Q At that time – let me – let me back up. Do you remember whether that was in June or July or can you give us an approximate date?

A I – I really can't. I don't – I don't remember if – if the time that we looked at Wanda was my first time or my second time down there, I really – I really don't remember, I'm sorry.

Q Okay. Tell us how you first learned of a patient named Wanda Johnson.

A The social worker that was handling her case asked me if I would be willing to take a look at a patient that they had been trying to discharge and without any avail to other facilities and that she was getting a lot of pressure to discharge this person due to they knew they weren't going to get paid for this person.

Q Do you recognize the name Nancy Fred?

A Correct, it was Nancy Fred.

[p. 24] Q And Nancy Fred is the person who you had this conversation with?

A Correct.

Q And was it Nancy Fred who initially asked you to look at Wanda Johnson's situation?

A Yes.

Q Do you remember whether that conversation with Nancy Fred took place at the first visit down to Humana or the second?

A I don't remember. It was – I – I really don't. I know it was the day that I took a look at Wanda and gathered information and took back to the facility.

Q All right. The day that Nancy Fred had spoken to you initially about Wanda Johnson, had you evaluated or taken a look at other patients that day?

A I think they had me look at maybe one other. I – it's – you know, when you're a marketing person, you're making so many marketing calls it's hard to remember how many you look at at each visit.

Q When you would look at a – at a prospective resident in a hospital, what kinds of things were [p. 25] you looking for?

A Well, the nurses would want me to – and each DON was different as far as what kind of information that they would want me to get copies of them for them. They would want information about medication, level of care, that a resident's cognitive ability, whether they're ambulatory, size of resident, those type of things.

Q Do you recall whether or not you had been scheduled to see this other patient, the one other than Wanda, had you been scheduled to see her prior to the

time you came down or was that also someone that they asked you to see once you got there?

A I think it was kind of spur of the moment.

Q All right. Do you recall what, if anything, Nancy Fred told you about Wanda Johnson's physical condition and her physical needs during that initial visit?

A That she was very heavy care, that she was starting to respond some, that they were hoping that she would eventually be able to – to be rehabilitated, that she had a lot of problems [p. 26] with temperature, maintaining temperature and I think – well, respiratory problems in the past were some of the things that they were struggling with, some family issues, things like that.

Q What did Mrs. Fred tell you about Wanda's family status?

A She said that the husband had – had left and I believe moved in with a girlfriend possibly, that Wanda's family then, mother or aunt, was then taking care and taking the responsibility for her, that Mr. Jackson really wasn't coming around too much.

Q Now, you said Mr. Jackson?

A Or her husband, Wanda's.

Q Mr. Johnson?

A Mr. Johnson, sorry.

Q Did Nancy Fred indicate to you anyone in – in particular who was – who was placing pressure on her to discharge Wanda?

A She didn't mention any names, but she said she was just receiving pressure from the hospital that, you know, that we needed – that she needed to find placement for this person.

[p. 27] Q Did she tell you or – or name any of the other facilities that had considered Wanda and turned her down?

A She named several but I can't remember them. You know, I think she named a couple that – that she had worked with and came close to maybe admitting and then they fell through for her at the last minute.

Q Did she indicate to you the reason why those other facilities turned her down?

A She may have but I don't remember exactly what they were.

Q Tell me specifically what – as best you can recall what Mrs. Fred told you about the reasons that she needed to have Wanda Johnson transferred or discharged.

A It was basically that they had had her for several months and they – they knew that they were not going to get paid and that they needed to get her discharged.

Q Did she indicate to you whether or not application had been made for Medicaid benefits?

A I think they had attempted possibly and maybe not [p. 28] everything got done because I know the administrator at Crestview had to do a great deal of work trying to get Medicaid application made for her. So it may have been started and kind of the ball dropped or may

have been started and Randy picked up where they left off, I'm not sure what.

Q After this discussion with Nancy Fred, did you then actually have an opportunity to go in and – and look at Wanda Johnson and evaluate as best you could her condition?

A Well, I didn't – I didn't evaluate but I always like to always go in and introduce myself to people. So I did go in and I – I believe I probably told her hello, who I was, what I was there for.

Q As best you can recall, can you tell us what your observations of Mrs. Johnson's condition were on that date?

A Wanda, if I – she was a rather large woman, not real responsive but did – I remember I think when I called her name she did look at me. She really could not talk to me or answer questions [p. 29] or anything like that, but she did seem to be somewhat alert to her surroundings. Just from looking at her, not being a medical person, it was – I could tell, though, obviously that she took a lot – took a lot of care, you know, because the way they had her positioned with a lot of pillows and this and she didn't move at all while I was in there.

Q Following your evaluation, to what extent you evaluated Wanda –

A Uh-huh.

Q – do you remember what your comments to Nancy Fred or anyone else at Humana were concerning Wanda and – and your feelings concerning her transfer or her discharge?

A Well, I told Nancy that I would contact one of – one of our facilities to see if they would be able to take her, you know, that I could not make any promises while I was there because it would be up to the facility as to whether or not she could be accepted into them and that we would, you know, get back with her as soon as we could.

Q Were you required at that point to take [p. 30] information from the hospital and deliver it to someone at Hometown?

A Correct. I did – I called the – the Mayfair facility which was Hometown's largest facility and the DON gave me a list of – of documentation that she would like me to have Xeroxed from the hospital to bring back with me to help her with evaluating how many nursing hours and the level of care that would be required for Wanda.

Q Now, was this call made from Humana Hospital in Louisville?

A Uh-huh, I think so. I believe I did.

Q And was it made shortly after your actual evaluation of Wanda?

A Yes.

Q Who was the director of nursing at Mayfair at that time, do you remember?

A It's on the tip of my tongue. No, I can't remember what her name was. If I heard it, I'd say yes, that was – I'm really bad with names, I'm sorry.

Q All right. So in any event, you called whoever the director of nursing was at Mayfair?

[p. 31] A Uh-huh.

Q And they gave you a list of documents that they needed?

A Correct, that they would like to have.

Q And did you get those documents from someone at Humana?

A I gave Nancy the list of items that we wanted and she took care of putting together a packet for me to take back with me.

Q Did she put that packet together for you to take back on that date?

A I believe, yes.

Q Did Nancy Fred or anyone else at Humana tell you anything else about Wanda Johnson during your visit there in Louisville or express to you any other opinions or – or encouragement with respect to accepting Wanda, anything of that nature?

A Well, they said, you know, we hope you can really help us out and, you know, typical when a – typical kind of response you get from a discharge planner when they're struggling and panicked to find placement.

[p. 32] Q And would these statements also have been made by Nancy Fred?

A Yes.

Q Was she the only person that you talked to at Humana concerning Wanda Johnson?

A I believe so.

Q So if I understand you correctly, you left Humana Hospital with a package of information concerning Wanda Johnson?

A Correct.

Q Who did you deliver that information to?

A It was delivered to the DON at Mayfair.

Q Do you know how long after your visit to Louisville that was delivered?

A I – I drove right back to Indianapolis that day so if I got back before quitting time it went that day.

Q Otherwise?

A It would have gone the very next morning.

Q After you delivered the information to the director of nursing at Mayfair, did – did that director of nursing follow up with any phone calls to you inquiring about anything else [p. 33] concerning Wanda Johnson's condition?

A I don't believe so. She may have called down there and talked to the nursing on the – on the unit.

Q But as far as the director of nursing talking to you, she did not?

A I don't believe so.

Q Following your trip back up to Indianapolis from Louisville when you received that information about Wanda, do you recall when it was that someone within your facility next talked to you concerning Wanda Johnson?

A Could you say that again.

Q I'm sorry.

A I – I didn't get the question.

Q After you had delivered the information from Humana to the director of nursing at Mayfair –

A Uh-huh.

Q – were you involved any longer in the process of determining whether or not any of your facilities would accept Wanda Johnson?

A No, you know, they might ask me another question or a name or a phone number, but once I give them [p. 34] the referral, I'm done with the case and it's up to the facility to make the determination whether or not they want to admit or not. Mayfair chose not to because they were – they had a great deal of number of skilled individuals in the facility and did not want to take another skilled patient at that time. And then it was determined I believe by, again, Ms. Tobey that we would pass the referral on to Crestview.

Q Now, were people from Mayfair or from Hometown contacting you in the interim and updating you on where we were with respect to Wanda Johnson's referral?

A Yes, as common courtesy, being the marketing director, it was also my job to find out, you know where are we with referrals, where are we with admissions, what's the bed count, things like that. So they would keep me updated.

Q Did you relay to anybody at Mayfair or Hometown Living Centers the comment made by Nancy Fred

that they were not getting – getting paid for Wanda Johnson, did you tell anybody within your facility or your organization about that problem

* * *

[p. 45] might want to start looking around to make sure I had something stable.

Q When you were with the company, were you on a salary or were you paid a commission based on referrals?

A A salary plus commission.

Q And how did the commission work?

A Commission would work that I would find their referral, if the admission panned out and the resident maintained a number of days in the facility and the company received payment, then I would receive a bonus.

Q And tell me how the bonus worked or was it based on a percentage or –

A It was just a flat, a dollar amount per resident.

Q And how much was it?

A Three hundred.

Q Three hundred?

A And then Daphna changed policy at the beginning of '93 that bonuses would be split between me and the administrator.

Q Prior to that time, the administrator did not get a bonus?

* * *

[p. 51] remember regarding your discussions with Nancy Fred at the University of Louisville Hospital?

A Yeah, I believe so.

Q Okay. I take it you didn't tell Nancy Fred that Crestview had never received a patient, what you called heavy care patient, this was its first; correct?

A It was their first extremely heavy care patient.

Q And you didn't tell that to Nancy Fred or Nancy Fred to your knowledge wasn't aware of that?

A I told Nancy that we did have skilled patients in the building and we have had skilled patients in the past.

Q The initial conversation with Nancy Fred related to Mayfair, though, did it – didn't it?

A Correct.

Q Okay. And you told us that after the patient was referred to Mayfair and you came back here you didn't have any further contact with Nancy Fred; is that correct?

A When Mayfair would not take her, I had to call Nancy and tell her what facility I was referring it to.

[p. 52] Q Okay.

A That's common courtesy.

Q Okay. And – and at that time, you didn't tell Nancy Fred that Crestview had never taken a – or this was its first heavy care patient, you – you simply told her it was a skilled nursing care facility?

A Uh-huh, and they would have to evaluate her whether or not they would be able to take her.

Q All right. The conversation you had with – is it Ms. Daph – Daphie, is that the name?

A Daphna.

Q Daphna, I'm sorry.

A That's okay.

Q I'm been mispronouncing it. Daphna, did Ms. – Ms. Daphna give you some reason why she thought Ms. Ferguson may be reluctant to receive this patient?

A No.

Q Okay. Was it customary for Ms. Daphna to tell you to tell the director of nursings at – at these facilities to have an open mind on – with respect to patients?

* * *

[p. 64] Q Okay. Crestview in – in July of '92 had the capability of administering IV medications; correct?

A That's my understanding that they did have IV certified nurses.

Q Okay. We've talked a little bit about heavy care and I'm going to represent to you that Ms. Johnson when she was transferred to Crestview had a tracheostomy, she had a foley catheter and a nasogastric feeding tube, would that meet what you are using the term heavy care?

A Correct.

Q And you told us that Mayfair had those patients before July of '92 and this was Crestview's first such patient?

A Well, they had had patients with tube feedings in the past, they had had patients with catheters in the past as well, but they did not have I don't think anyone with all the multiple things at that time. They had patients there at the time that had some of the other items that would classify them as skilled care.

Q Do you recall when you talked to Ms. Ferguson,

• • •

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CAUSE NO. C-93-0544L-M

[Caption Omitted In Printing]

The video deposition upon oral examination of CHARNA Y. TRESER, • • • on the 25th day of January, 1994, • • •

• • •

[p. 63] about that six p.m. entry on your nursing notes. That refers to the orders that you received from Dr. Shatara. The first order that you received was apparently to determine Mrs. Johnson's code status; is that correct?

A Uh-huh.

Q Now, explain to the jury just in case they don't understand, what do you mean by full code, the various levels of code that – that we're discussing?

A Okay. A full code is that the – the family would request that a resident if they go in distress or – or have a problem where they need to be seen in a better equipped facility do all that you can for them.

Q And that's full code?

A Yes.

Q All right.

A A no code is the family would like for that person if they're in a distress or a situation where they may be RHC –

Q And what's RHC?

A They may de – be deceased.

[p. 64] Q Okay.

A Or will get to that point where they're – they want them to go on their own with no help at all, just make them comfortable.

Q All right. So in a no code situation, you make the patient comfortable?

A And –

Q And wait?

A – you would monitor them and just let them go at their own.

Q And let them expire if that's what happens?

A Yeah, on their own.

Q Now, was it unusual for you in receiving a patient in at Crestview and when you made your initial call to the doctor on – on call, was it unusual that the first order that he would give to you was to determine the code status for that patient?

A (No response).

Q Let me – let me rephrase the question maybe. Do you – do you recall ever –

A I understand the question.

Q Okay.

[p. 65] A I'm just trying to see how I would phrase it.

Q Okay. Well, let – take your time.

A I've never had that said to me before.

Q Okay. So it was unusual that that was his first order?

A Well, to me, I never had it said. It might have been said to RNs, you know, because every – every resident has to have a code status, you know, I mean that's the patient family's right. That was the first time it was said to me.

Q So normally when you make that initial contact to the doctor when you're admitting a patient other orders are given other than the request for determination of code status?

A Yes.

Q Do you know why in Mrs. Johnson's case that was Dr. Shatara's first order to you?

A No, I don't.

Q Based on your evaluation of Wanda, do you think or do you have an opinion as to whether or not it had anything to do with her condition when she was presented to the nursing home?

A My opinion?

[p. 66] Q Yes.

A Yes, he probably wanted to know the code because, you know, the condition she was in.

Q Now, apparently after you talked to Dr. Shatara there was a call that was made to one of Wanda's family

members and eventually I believe at seven-forty-five, although it's not in – in the notes that you took, there is some indication that a family member had called and discussed with someone her code status. Do you remember someone relaying to you what Wanda's family had told the people at Crestview concerning code status for Wanda?

A Do I remember?

Q Do you remember what her code status was after –

A After she talked to –

Q Correct.

A I can't remember if it was told to me or not because at this time Lynnette took over to a certain extent, you know, what was going on.

Q Ms. Treser, was Wanda Johnson's condition when she presented herself or was presented to your nursing home, was it more severe than any other [p. 67] patient that you can ever remember accepting at Crestview Nursing Home?

A Her condition, yes, it was. She was in – to my – of my opinion, she was in pretty bad shape.

Q And isn't it true, Mrs. Treser, that her condition was so severe when she was presented to your nursing home that you thought she was going to die before she was able to be placed someplace else?

A Let's say that could have been a possibility.

Q You thought of that, did you not?

A Yes.

Q And wasn't that the reason that it was so important to determine her code status?

A Yes.

MR. MATTINGLY: Thank you, Ms. Treser.

REDIRECT EXAMINATION,

QUESTIONS BY B. TODD THOMPSON:

Q Ms. Treser, I have just a few more questions. As I understand it, all patients at Crestview had a code status?

A Yes. Everyone has a code status, yes.

• • •

[p. 69] A I have some that were admitted two-thirty, three o'clock.

Q Okay. The norm, the routine would be that most patients come in sometime before the second shift?

A I don't know if you would say routinely. Let's just say it happens that way sometimes.

Q You were asked about this patient's – Mr. Mattingly asked you some questions about Ms. Johnson's condition and whether you thought she might die and questions to that effect. We know that by – at least by eleven o'clock p.m. when you left the nursing home you charted that there were no signs or symptoms of distress for Ms. Johnson; correct?

A Yes, I did chart that.

Q Okay. And you've told us that you communicated to Dr. Shatara Ms. Johnson's condition and you deferred to his judgment as the physician as to what medical treatment or what would be done for Ms. Johnson; correct?

A Uh-huh.

MR. THOMPSON: Okay. That's all. [p. 70] Thank you.

RECROSS-EXAMINATION,

QUESTIONS BY JOSEPH H. MATTINGLY, III:

Q Ms. Treser, just one further question. In response to Mr. Thompson's question, you – you related to us the routine at Crestview Nursing Home for determining a patient's code status. Let me ask you, had – had you prior to Wanda Johnson ever admitted a patient, done the initial evaluation and actually were – were the first person at Crestview to – to admit a particular patient, had you done that before?

A No.

Q You had never done that before?

A No.

Q All right. Had you ever been prior to Wanda Johnson the first person at Crestview to talk to the doctor to get the doctor's orders?

A On a new admit, I've took and verified, yes – well, I have never did a total admit before, no, because everybody does it – the RN, if there's an RN there will do

it, you know, and if I – if she wants me to follow her up or help, I will

* * *

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CAUSE NO. C-93-0544L-M

[Caption Omitted In Printing]

* * *

The video deposition upon oral examination of JOHN W. STUY, M.D., * * * on the 25th day of January, 1994, * * *

* * *

[p. 7] A Several months. Several months.

Q Do you know approximately what month it was that you last saw Wanda Johnson?

A I believe it was in January of the following year that I had her discharged.

Q And was that discharge from Midwest Medical Center?

A That's right.

Q So, Doctor, was Wanda Johnson hospitalized at Midwest Medical Center during the entire time that she was your patient from July 25, 1992 through January of 1993?

A That's correct.

Q In addition, Doctor, to having treated Wanda Johnson for a period of approximately six months, have

you also had an opportunity to review some of the medical records from Crestview Nursing Home here in Indianapolis and also some of the records from the University of Louisville Hospital in Louisville, Kentucky?

A Yes, I have.

Q Could you tell us generally, Doctor, with respect, first of all, to Wanda Johnson's [p. 8] condition prior to her transfer from Louisville, Kentucky, could you tell us what you recall as being significant, significant conditions with respect to Mrs. Johnson that you were able to glean from the medical records that – that you saw from the University of Louisville?

A I saw two days of progress notes written by physicians at Humana Hospital.

Q Do you remember the dates of those admissions or those –

A 23rd and 24th of July.

A Two days prior to her transfer?

A That's correct.

Q All right.

A That's correct. I believe she was transferred on the 24th. And on both of those days, the physician writing the progress note commented on a fever that she had and that he had initiated oral antibiotic and that she also had an elevated white blood cell count. The white blood cell count when it's elevated usually reflects active infection, although there are other medical conditions that can cause it to be elevated as [p. 9] well. And on the 24th, if I

remember correctly, she had a temperature that was higher than on the 23rd.

Q Doctor, we have had some previous testimony in this case from the nurse who was on staff at the University of Louisville Hospital on the date that Mrs. Johnson was transferred and her testimony was that on the date of Wanda Johnson's transfer her – Wanda's white blood count was twenty-two thousand.

A Uh-huh.

Q Could you tell us whether a white blood count at that level is significant to you as a – as a specialist in internal medicine; and if it is, tell us why it is significant and what it – what it showed?

A Well, it's quite high. A normal white blood cell count while it varies a little bit from laboratory to laboratory what is considered their upper limit of normal, twenty-two thousand is very high, and in someone with a fever and an elevated white blood cell count, my first concern is that she has an active infection and a serious [p. 10] active infection with a white count that high.

Q All right. What, Doctor, do you generally see as – as a normal white blood count?

A Again, it can vary a little bit from laboratory to laboratory, but most upper limits of normal would be ten thousand five hundred, ten thousand eight hundred and, again, that varies from lab to lab.

Q The nurse who was present at the University of Louisville Hospital at the time that Wanda was discharged also noted that – that Wanda had cloudy urine or a hazy yellow urine, is that something that's significant to

you in reviewing records; and if so, what is the significance of that?

A Well, that could reflect active urinary tract infection, infection within the urine, in the bladder, possibly even the kidney.

Q Do you recall reading anywhere else in the medical records that you reviewed during those last two days of Wanda's stay at the University of Louisville Hospital about a urinary tract infection?

A The physician writing the progress notes commented that he felt the elevated temperature probably was a result of the urinary tract infection and that's why he initiated the antibiotic that he picked.

Q Generally, Doctor, when – when a physician is reviewing a patient's progress and notes things like we've just talked about, a white blood count that's elevated and elevated temperature, cloudy urine and when, as you said, the doctor administers or elects to administer antibiotics, is there any kind of standard in – in – of good medical practice as to the length of time that that doctor should review to determine whether that particular antibiotic is – is taking care of the problems that he's found that are evidenced by these factors that we've talked about?

MR. THOMPSON: Before he answers that, let me object to this line of questions from this treating physician who has not been identified as an expert witness to render opinions about the hospital care at University of [p. 12] Louisville Hospital. My understanding is he

is a fact witness. We haven't brought forward the outstanding requesting expert witnesses and their opinions. This has not been provided to us today, and if opinions are sought here and the court permits them, we will ask to come back and redepose the witness after we've had an opportunity to prepare to cross-examine him on expert opinions.

Q Would you like me to repeat the question, Doctor?

A Yes, I think you lost me.

Q All right. Doctor, we're – we're talking about what is expected or what is reasonable medical care in a situation where a doctor has identified what appears to be active infection and has prescribed antibiotic treatment for that infection. Is there a certain period of time that you normally would expect to have to monitor a patient to determine whether the antibiotics that you have prescribed are going to adequately treat the infection that you found?

A Well, what you would typically do is obtain a culture of the potential source of infection. So [p. 13] in this case, you would obtain a sample of urine and send it to the laboratory for culture and sensitivity; by that, the laboratory would try to grow bacteria to see if there is an active infection, identify those bacteria and then they can in the laboratory check various antibiotics and see if those antibiotics would successfully kill or eliminate those bacteria. So you identify the organism then you can actually check a number of antibiotics and see if those are successful in treating that particular infection.

Q Generally is this something that takes a period of days?

A Within 48 hours they should be able to render a preliminary report and within 72 hours they should be able to give a positive identification.

Q If a physician does not follow through with this analysis of the antibiotic treatment that he's administered, would that generally in your opinion be outside the normal standard of good medical care?

MR. THOMPSON: Same objection.

A So I can talk? I think in this particular [p. 14] patient because she is immunocompromised, she's lacking a spleen, also the fact that she has a predisposition to pneumonia, she has a predisposition to urinary tract infection because of a catheter residing in her bladder and the fact that she's been in the hospital a long time and, therefore, exposed to bacteria and organisms that are not typically found in the community, organisms that are typically more easily treated, I think she should have had a culture obtained and looked at prior to her release to be sure that this antibiotic would address that infection successfully.

(A discussion was held off the record.)

MR. MATTINGLY: To go on the record with respect to Mr. Thompson's objection to this witness expressing opinions about the care rendered by the University of Louisville Hospital, I understand that the objection is that this witness has not been identified as an expert and that that will be a continuing objection and we would have no problem if it's considered that rather than

having to interpose an objection to [p. 15] each opinion that's rendered by Dr. Stuy or any question asking for Dr. Stuy to render an opinion today.

MR. THOMPSON: With that understanding, in light of the fact that we are on a videotape, we will not interpose those objections and it's understood that they are continuing and that they are not waived.

MR. MATTINGLY: That's correct.

Q Dr. Stuy, based on your review of Wanda Johnson's medical records from the University of Louisville during the last couple of days that she was there, was her condition such that – that she required continuous medical attention in a hospital setting?

A I think, as I mentioned previously, that cultures of the presumed infection should have been obtained and looked at first prior to transfer to be sure that the antibiotics that they picked would successfully treat that infection. If they picked an antibiotic that would not successfully treat an infection and she were released, because of her generally immunocompromised state, lack of [p. 16] spleen, prolonged hospital stay, foreign bodies in the form of catheters, there is some risk that the infection would get worse and could cause her harm.

Q So, Doctor, because of that risk, did her condition require that medical personnel such as doctors and – and other people who you would expect in a hospital be able to treat her in case one of these complications arose?

A Maybe I'm not quite following your – your line of thought.

Q All right. Was Wanda Johnson's medical condition such that if she did not have available to her medical attention her condition could possibly have deteriorated very quickly?

A Yes.

Q Describe again for us the types of health risks or conditions that under Wanda Johnson's condition she may have suffered from, not necessarily that she did suffer from, but the risks that she – that were involved in her condition.

A Her ability to fight off infection was [p. 17] compromised. If the infection were not to be checked or treated with the antibiotics successfully, it could spread into the bloodstream and cause a condition called sepsis which if not treated quickly can result in death.

Q Doctor, based on your experience and treatment of Wanda Johnson and your review of her medical records at Humana Hospital, University of Louisville, do you have an opinion as to whether Wanda Johnson's transfer from Louisville to Indianapolis on July 24, 1992 was consistent with accepted medical standard of care?

A I don't think it was.

Q Doctor, would the risks that you've previously told us about, would a – a trip in an ambulance from Louisville to Indianapolis, thaf period of time that it would take to – to travel that distance, would you consider that a dangerous situation for Wanda Johnson in her condition?

A I think she should have remained in the hospital setting until they could document that the antibiotics that

they picked could successfully treat the suspected infection.

[p. 18] Q Doctor, you're familiar with Crestview Nursing Home, are you not?

A Somewhat.

Q And tell us how you are familiar with that or how you were familiar with that as it existed on July 24th and '5th of 1992?

A One of the members of my group takes care of – or took care of residents of Crestview Nursing Home and that's how I became involved in Wanda Johnson's care since I was covering for him on the weekend of the 25th. I know that they offer intermediate and skilled care. I spoke with nursing staff on that Saturday morning to get more information about her and to get some information about what they offer in terms of care. I have not physically been inside Crestview nor have I admitted residents to Crestview Nursing Home.

Q Based on your conversation with that representative from Crestview on that Saturday morning and what she told you about what Crestview was able – able to offer a resident like Wanda Johnson, did it appear to you or do – [p. 19] do you have an opinion as to whether or not Crestview Nursing Home was capable of providing the facilities and services to adequately care for Wanda Johnson in the condition that she was in when she was presented to them?

A I asked if they took care of individuals who had suffered traumatic injuries such as Wanda Johnson and the nurse that I spoke to that morning stated to me that

Wanda Johnson was the very first patient that they had ever received which suffered any sort of traumatic injuries of the nature that she had.

Q Doctor, given what you knew about Crestview Nursing Home and what you know about Wanda Johnson's condition when she was at the University of Louisville, can you think of any medical reason, any medical – medically beneficial reason for a transfer of Wanda Johnson from University of Louisville in the condition that she was on – in on July 24, 1992, can you think of any medical reason, any benefits she could have gotten from that transfer?

A No, not at all.

[p. 20] Q Doctor, one of the diagnosis that I believe that you made once Wanda Johnson was admitted to Midwest Medical Center was that she had, Wanda had active pneumonia; is that correct?

A That's correct.

Q Did you have an opportunity to review the medical records from Crestview and from the University of Louisville to determine whether that pneumonia existed prior to her transfer to Indianapolis?

A When I spoke with the nurse that morning and then I reviewed the records from Crestview Nursing Home, they mentioned that on her arrival that Friday evening that she had a fever of 100.5 axillary, which means under the arm. Which would roughly translate to a temperature of 101.5 if you were to check it by mouth which is what most people are familiar with. They also did mention in their nursing notes that she had abnormal

breath sounds at both lung bases, something that they call rales which can be heard when someone has pneumonia. They also commented on some purulent or sputum that was being produced that looked like it might be infected.

[p. 21] Q Do all of those things indicate active pneumonia?

A Very suspicious for it. Very suspicious for it. There was mention made of a chest x-ray at Humana Hospital on the 23rd after a procedure called a bronchoscopy; unfortunately, the records that I had didn't show that report. I don't know if it actually was done and if it was done I don't – I don't know what the readings were.

Q Doctor, in your practice here in Indianapolis, do you frequently work with the social worker staff at the various hospitals around Indianapolis to place patients after –

A Oh, yes.

Q – they're stable?

A Oh, yes.

Q Tell us, Doctor, what you expect of a social worker when that social worker is going out to – to attempt to place a patient at a – at a new nursing home facility, what do you expect of your social worker to find out about that facility before the transfer is made?

A The social worker will need some medical information when she talks to the nursing [p. 22] facility in order to determine if that facility can meet their medical needs. Initially, they'll break down medical needs into

what we call intermediate level of care versus skilled care which means that you have more nursing time per patient with skilled care than you would with intermediate care and then if they need ancillary services like physical therapy, occupational therapy, speech therapy, whether that facility offers it, whether they're familiar with that type of problem that the patient has.

For example, if I had a patient with Alzheimer's disease and who didn't think clearly, were they familiar with taking care of individuals like that, would they have common sense safeguards in place to make sure that patient didn't get hurt because they didn't think clearly.

So I rely on the social worker to get some information for me, particularly if it's a nursing home or extended care facility that I'm not familiar with. I typically contact and talk with the nursing facility as well when it's one [p. 23] that I'm not familiar with and it's one of my patients.

Q Would you consider it to be outside the standard of good nursing – or good social worker care for -for one of your social workers not to perform those functions that you've just detailed to us when they're attempting to transfer a patient to a new facility?

A She's not doing her job if she doesn't follow through on those things that I mentioned.

Q Tell us, Doctor, if you were supervising a social worker who was transferring a patient with symptoms similar to the symptoms that Wanda Johnson had when she was in Louisville, Kentucky prior to her transfer, what kinds of things would you expect for your social

worker to have inquired about with respect to the nursing home that – that Wanda Johnson was going to be transferred to?

A First, do they offer skilled nursing care; second, have they ever dealt with a patient like this before, have they dealt with people that have undergone significant trauma and have they [p. 24] dealt with – excuse me – successfully in terms of trying to rehabilitate them and with their particular special needs. I think I mentioned before that when I spoke with the facility that morning when I saw the patient they mentioned that this was the first time that they had encountered a patient like Wanda Johnson. They had not dealt in the past with patients with multiple wounds like Wanda Johnson had.

Q So, Doctor, if the social workers at the University of Louisville Hospital failed to check into those aspects of the services that could be provided by Crestview Nursing Home, do you have an opinion as to whether their activities were within the standard of good social worker care?

A I don't think they had the best interest of Wanda Johnson at heart. I should mention that I confirmed this by talking to the medical director of the facility to see if indeed they had dealt with patients like this in the past and they had not.

Q You're talking about the medical director at Crestview Nursing Home?

[p. 25] A That's correct. That's correct.

Q So let me make sure I understand your comment. You're saying that if the social worker at Humana didn't

check into these things then you don't think that she had the best interest of Wanda Johnson at heart?

A No, I don't.

Q Doctor, you indicated that one of your partners was at least on July 24th and '5th of 1992 medical director at Crestview Nursing Home?

A That's right.

Q Do you recall – first of all, is your medical group the medical directors for that facility today?

A No, we're not.

Q And when did you cease providing that service to this particular nursing home group approximately?

A I'm not sure of the actual date. I would say sometime within two months but that – that I don't remember specifically, but probably within two months of her arrival at the nursing home, perhaps three.

Q Did your medical group's decision or the mutual [p. 26] decision between your medical group and the Crestview facilities to part ways have anything to do with their acceptance of Wanda Johnson in this particular case?

A I didn't directly speak with the administrator particular – specifically about that. I did speak with the physician who was supposed to be responsible for her and so what I received was secondhand information from him that this was one reason why we were no longer involved with their facility because of complaints or objections brought up by doctors in our group; but again, I didn't hear this specifically from the facility, this was just told to me by other physicians who attended there.

Q Do you or members of your medical group accept referrals from Crestview today?

A I'm not sure I follow you, accept referrals?

Q Okay.

A They typically have a physician assigned to them, usually the medical director or they might have private physicians that follow them at the nursing home so those physicians would be [p. 27] following those patients if they went to the hospital. I can't myself recollect seeing a patient from Crestview Nursing Home for quite some time. I have taken care of one other patient from Crestview Nursing Home who also arrived in the emergency room and I happened to be on call, but it's been quite some time, well over a year since I've seen any residents from Crestview Nursing Home.

Q Doctor, could you tell us a little bit about what injuries, if any, or what deterioration in Wanda Johnson's condition you noticed as having been caused by her transfer from the University of Louisville Hospital?

A When I met her Saturday morning, she had a very high fever, she was breathing very rapidly, clinically she demonstrated evidence for pneumonia and by x-ray she also demonstrated evidence of pneumonia. Her white blood cell count was high. She was flushed, sweaty, hot. I felt she demonstrated all the physical findings and laboratory findings consistent with early sepsis or overwhelming infection.

[p. 28] Q And –

A If this is not treated, then it results in death.

Q Doctor, was Wanda Johnson's condition substantially worse when you saw her on Saturday morning than what it appeared to have been just prior to her transfer from the University of Louisville Hospital?

A Her res – yes, based on the notes that I read, her – her respiratory rate was very rapid, her pulse was very rapid, her temperature was 105 at the nursing home just prior to transfer to the hospital which is higher than at the hospital – Humana Hospital; so yes, she was worse than – than at Humana Hospital.

Q And did the fact that she was transferred from that hospital to Indianapolis have anything to do with the deterioration in her condition in your opinion?

A It's not so much where she was, it's the treatment that she needed. If she had remained in the hospital, I'm sure she would have demonstrated the same problem and then it would have been treated there. The risk or the danger [p. 29] is that she was outside the hospital for a period of time as she got worse and not immediate – and not directly under the care of a physician that could take care of her quickly. So, you know, there is a window of time when she was transferred from the hospital before she arrived in the hospital. I think it was about eighteen hours between arrival at the nursing home and when she was in the emergency room, and during that time, she deteriorated significantly.

Q Doctor, had she remained in a hospital setting and had medical attention available to her, is it probable that this episode of – of deterioration in her condition could have been avoided?

MR. THOMPSON: Objection to the form.

Q Doctor, in your opinion, could the deterioration, the rapid deterioration in Wanda Johnson's condition which you've described to us, in your opinion, could that have been avoided had she been in a hospital rather than a nursing home?

A She probably – well, I'm sure they would have noticed the deterioration in her condition and [p. 30] she probably wouldn't have gotten quite as far along because they would have intervened more quickly and addressed her problems. She's had recurrent pneumonia in the hospital at Humana before and – and I'm sure they would have noticed the elevated temperature and addressed her problems.

Q Would it be a fair statement, Doctor, that the further the – the more significant the digression in her condition the longer it would take the hospital, whether it was Midwest or whether it was Humana, to bring Wanda Johnson back to the condition she was prior to that digression?

MR. THOMPSON: Objection. Form.

A Can you run that question by me again.

Q Sure! Doctor, in your opinion, would the degree that Wanda Johnson's condition deteriorated –

A Uh-huh.

Q – have anything to do with how long it took to – to treat Wanda Johnson and bring her back to a stable position – condition?

A She was started on an antibiotic that did not [p. 31] address what was cultured from her urine and what was ultimately cultured or grown from her sputum. So during the time that she was on the antibiotic that was started at Humana Hospital until the antibiotic therapy she received at Midwest, the infection that she had was not being treated successfully and the fact that she had such a high fever and had the signs and symptoms of early sepsis just reflect the infection getting worse and worse.

If another day had gone by, I – she might have passed away if she had remained in the nursing home still on that same antibiotic, tough to tell. It varies a little bit from person to person how quickly that can occur. In her case, because of the fact that she had a catheter in her bladder which makes you more prone to infection, the fact that she didn't have a spleen which helps fight off certain types of infection, she's at higher risk for infection and at higher risk for deteriorating more quickly.

Q Doctor, in your opinion, does the degree of family support that a patient in Wanda Johnson's

* * *

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CAUSE NO. C-93-0544L-M

[Caption Omitted in Printing]

The deposition upon oral examination of KAMBIZ T. KARIMI, M.D., F.A.C.P., * * * taken on the 12th day of July, 1994, * * *

* * *

[p. 12] Q. Did you have any involvement as the medical director with the state regulatory agencies that oversaw nursing homes in the state? Did you ever meet with state regulators?

A. Uhn-uh. State regulators on this case or any?

Q. No, sir.

A. At anytime at all?

Q. As the medical director, I'm just asking whether part of your job was to prepare reports.

A. No, no, no. Part of our job was to meet every, I believe at that time it was every month, or have to look and see. By law we meet on a regular basis. It used to be every month, and now it's changed to every three months, quality assurance. Now it's just every three months, some places require every three months to discuss any type of policy procedures, problems, address the

problems. That's routine for all the nursing homes. They have to do it.

Q. Let me ask you a couple of questions about Wanda Johnson, You never treated Wanda Johnson, did you?

A. Never seen her. Never knew she was coming. I was the one who sent her out.

Q. And there is a note here that says on July 25, 1992, [p. 13] at 9:10 a.m., "Call placed to Dr. Karimi," and then you ordered her transferred out. Wanda Johnson, when she arrived at Crewstview [sic] she had a tracheostomy, and Crestview had the capabi1ity of caring for a patient with a tracheostomy, did it not?

A. Tracheostomy, it is not a very difficult thing to take care of. But they have a nursing staff take care of, and they were – at one time all nursing homes began to have so-called skilled facility to provide care for the patient with much more skilled case.

Were they able to take – to be honest with you, I don't know whether they were able to take care of it or not. I reviewed the chart. I read the chart after I heard there was some of this, and I just wanted to make sure what was my involvement in the case. And prospectively, they did not inform us about admission. Retrospectively, I think probably that was an inappropriate admission.

Q. At Crestview?

A. Yes.

Q. Are you saying that because you believe Crestview was not capable of providing the care Wanda Johnson [p. 14] needed?

A. Yes, knowing the patient now what I know about her. Again, I never saw the patient, nothing. They called me, said the patient's fever is 104. I assigned the patient immediately to one of our physicians. And she stayed in the hospital what, twelve hours, sixteen hours at most in there. And our policy is to see the patient within 24 hours skilled, and 48 hours nonskilled, and we send them out.

And now what I know about the patient, probably it was an inappropriate transfer.

Q. Why was it inappropriate for Crestview to admit Wanda Johnson or to accept her as a patient?

A. Well, there was a – I don't know. I didn't see documentation. I didn't know but they said she was febrile [sic] even on the way coming to Crestview. But then the physician, Dr. Shatara, said the patient was 100.5.

Q. Is that febrile?

A. Axillary, it probably is, but axillary. If it is oral, even if it's a fever, it's not that significant. Even as fever, 100.5, we send people home with 100.5. We send people back to nursing [p. 15] homes with 100.5.

Going back again to the tracheostomy, I will just have to guess that they have the nursing staff, they did have people who they thought they can take care of patients.

Q. Take care of patients with a tracheostomy?

A. Yes. I mean, it's not that difficult to take care of a patient with a tracheostomy.

Q. There were skilled nurses at Crestview, were there not?

A. I'm sure, when you are an RN. Just like me, I'm an M.D. I can do neurosurgery if I want to, but if I mess it up, I'm grilled. An RN, they can do anything they want as long as they have experience.

Q. Well, would you agree with me that Crestview should not have accepted a patient with a tracheostomy if they did not have a nurse trained to care for that patient?

A. Sure, definitely.

Q. And Crestview, the administrators at Crestview would be the people who should know what the capabilities of their nurses are; correct?

A. Oh, yes, definitely.

Q. [p. 16] A patient with a urinary tract infection can be treated on an outpatient basis; correct?

A. Yes.

Q. Patients in nursing homes get urinary tract infections?

A. All the time.

Q. You treat them there. You don't move them to a hospital, do you?

A. No. As a matter of fact, these days now there is so much changes that most of the patients, almost all patients are treated at the nursing home unless they are

septic. That means they are what we call the blood, the bacteria has gone to the blood. Even then we decide, we have made a decision whether we should transfer the patient, should we treat the patient in the nursing home. So not everybody goes to the hospital.

Q. You discharge patients from hospitals into nursing homes yourself?

A. Have I discharged patients from a hospital to the nursing home?

Q. To the nursing home.

A. Yes.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CAUSE NO. C-93-0544L-M

[Caption Omitted In Printing]

• • •

The deposition upon oral examination of Taiseer Shatara, M.D., • • • taken on the 12th day of July, 1994 • • •

• • •

[p. 17] you for any reason based upon information you got from the nurse felt that that patient's healthcare was seriously endangered –

A. At that time I felt –

Q. – at that time you would have transferred her?

A. At that time, yes. But at that time the information, and I have to trust the person on the line that gave me the appropriate information.

Q. Okay. Doctor, you've told me that, that you need to trust the person on the end of the line.

A. Yes, yes.

Q. And I accept that. I'm asking a different question now. And that is that if you didn't feel comfortable with the information you got over the telephone, I assume you would have taken some steps to act on that?

A. Well, again, based on the information that was given to me at the time, I felt that the patient was stable enough.

Q. Okay.

A. At that time.

Q. Okay. Let me hand you a copy of a note that's dated and timed – it's dated, rather, July 24, 1992. Have

* * *

[p. 19] admission, would you look at those, please.

A. Yes.

Q. Do those appear –

A. That would be reasonable.

Q. – appear to be reasonable?

A. A patient who has been transported, yes.

Q. There is certainly nothing contained in the information in these notes that would indicate this patient is unstable or could not be cared for?

A. Not on the basis of this.

Q. You were aware at the time of Ms. Johnson's admission that she had a tracheostomy and a Foley catheter and an N/G tube?

A. I was told she had a tracheostomy. I don't remember the N/G tube. I remember she told me about the wound. That why I asked about the wound, and she stated it was as she stated in her note.

Q. Based upon your experience at Crestview, you were comfortable that they could care for a patient with a tracheostomy?

A. Yes.

Q. Dr. Shatara, Crestview had the capability, did it not, to obtain lab specimens, such as urine cultures [p. 20] and blood cultures?

A. Uh-huh, yes.

Q. And it was capable of managing a patient who had a urinary tract infection?

A. Yes.

Q. If a patient at Crestview was not responding to prescribed antibiotics for a urinary tract infection, could antibiotic therapy be modified in the nursing home setting?

A. In certain nursing homes, yes.

Q. At Crestview?

A. Yes.

Q. Is it fair to say that if Wanda Johnson had arrived at Crestview and you had received information to indicate she needed to be in a hospital, that you would have taken the necessary steps to transfer her?

A. Yes.

Q. Doctor, finally, is it fair to say that when you admitted Wanda Johnson to Crestview, based upon the information you received from Crestview, Wanda Johnson was stable and was an appropriate nursing home placement?

A. Now, repeat that question again.

[p. 21] Q. Would it be fair to say that at the time you admitted Wanda Johnson, would it be fair to say at the time you admitted Wanda Johnson to Crestview, based upon the information you received from Crestview's nurses, that she was stable and that she was an appropriate candidate for nursing home placement?

A. At that time, yes.

MR. THOMPSON: I want to go ahead and mark as Exhibit 2 the nurse's notes from Crestview.

(Defendant's Deposition Exhibit No. 2 was marked for identification)

Q. Doctor, there is a reference at the 6:00 p.m. entry regarding your discussion with the nurse, and it says that the nurse received an order to call the resident's family on res. code. Does that refer to resuscitating code?

A. Yes.

Q. Is that standard?

A. I usually do that with every patient, yes.

Q. Every patient that comes in there?

A. Yes, so this is not – at the hospital or the nursing home.

Q. Did you have any further contact with Crestview after

* * *

[p. 23] A. Not really. Just, you know, the initial information that this patient had a tracheostomy and open wound, but I did not get a detailed history that this

patient had other problems until later on after she was in the hospital.

Q. How did you learn of those other problems or that other history?

A. After the patient was hospitalized.

Q. And did you obtain that information by reviewing her records or by talking to other physicians?

A. By talking to other physicians. In fact, I did the cross-coverage for the physician who admitted her into the hospital.

Q. What significant history or other problems did you discover that you are referring to here.

A. If I had known that this patient had the complicated hospital course that she had, I would not have accepted the patient to be in a nursing home.

Q. And when you say the complicated hospitalization that she had, specifically is there anything that you are referring to?

A. From multiple infection to the complicated course requiring multiple surgery to intervene with certain [p. 24] infection, intra-abdominal infection that she had, and the need for her medical care that she required much more so than just being in a nursing home.

Q. Doctor, I know that you indicated that you don't recall the specifics of the conversation that was held between you and the nurse at Crestview at the time when Wanda was admitted. Do you recall specifically during that conversation whether or not anyone told you that

Wanda, that it was suspected that Wanda may have had a urinary tract infection?

A. Not really.

Q. So that information did not come to you?

A. No, that information did not come.

Q. Do you recall whether or not it was conveyed to you at that time that Wanda Johnson's white blood count had been elevated or was elevated?

A. No, not at that time.

Q. You were not advised at that time?

A. I was not advised of her white blood cell count.

Q. Based on your experience with patients who are transferred from a hospital to Crestview or any other nursing home, would it be a typical situation that the transferring hospital would provide much of the [p. 25] details of the patient's history to the nursing staff at the hospital prior to the time that the nursing staff contacts you?

A. Usually is the case you are provided with a discharge summary from the hospital.

Q. Do you have any knowledge or information about how much information was provided by the University of Louisville Hospital to Crestview nursing home or to the nurse who made the telephone call to you when Wanda Johnson was admitted?

A. Not really.

Q. Doctor, had you known about the complicated hospitalization that Wanda had experienced that you

described to us, had you known about the suspected urinary tract infection, had you known about the elevated white blood count that Wanda had in addition to the other information that you say you do recall the nurse providing to you on the evening of Wanda's admission to the nursing home, would you have done anything differently?

MR. THOMPSON: Objection to form.

A. I would not have accepted her.

Q. Doctor, when you say you wouldn't have accepted her, [p. 26] what do you mean?

A. I would probably have had her transferred to a hospital.

Q. Immediately?

A. Yes.

MR. MATTINGLY: Thank you, Doctor. That's all.

EXAMINATION,

QUESTIONS BY MR. THOMPSON:

Q. Doctor, a few more questions. I believe you just testified that you expected the nurse at the receiving facility at the nursing home to have a discharge summary; correct?

A. Yes. I wasn't told what she had. Sometimes –

Q. You've answered my question. Let me go ahead. Doctor, did you ask the nurse to read you –

A. I don't remember.

Q. Excuse me. Let me finish. Did you ask the nurse to read you the discharge summary from the University of Louisville Hospital?

A. I don't remember.

Q. You could have? You don't remember?

A. I don't remember. But let me – many times a patient

* * *

[p. 37] received some compensation for the work you did at Crestview?

A. Yes.

Q. Had you taken care of patients at Crestview prior to July of 1992 who had had a tracheostomy in place?

A. I really don't remember.

Q. Is that significant to you one way or the other?

A. No. I've taken care of since then. It really is not.

Q. At Crestview?

A. No, not at Crestview.

Q. At a different nursing home?

A. At a different nursing home.

MR. THOMPSON: I think that's all I have. Thank you.

EXAMINATION,

QUESTIONS BY MR. MATTINGLY:

Q. Doctor, just a couple of follow-up questions. The orders that you gave to the nurses at Crestview when you

talked to them the night of Wanda Johnson's admission concerning taking the vital signs and the frequency of those vital signs being taken, were those orders, whatever they were, based on the [p. 38] information that the nurse had provided to you at the time when she called you at 6:00 p.m. on that night?

A. Yes, sir.

Q. And, Doctor, would it be a fair statement to say that there was extremely important medical information about Wanda Johnson that was not made available to you on the night of her admission?

MR. THOMPSON: Excuse me. I object to the form. He's already testified he doesn't know whether he reviewed the discharge summary or not, so I object to it.

Q. Let me ask the question again: Doctor, would it be a fair statement to say that now, based on your knowledge of Wanda Johnson's case, that there was extremely important medical information about Wanda Johnson's condition that was not made available to you during that initial telephone call from Crestview to you the night of Wanda's admission?

MR. THOMPSON: Objection to the form.

A. Yes.

Q. Your answer again?

A. Yes.

MR. MATTINGLY: Okay. That's all.

* * *

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CIVIL ACTION NO.: C-93-0544L-S

[Caption Omitted In Printing]

* * *

The deposition of FRANK MILLER, MD, taken pursuant to notice by the Plaintiff on January 25, 1995, * * *

* * *

[p. 14] Q. Typically, Doctor, when a – when a policy is – is revised, is – is that revised policy circulated among the residents and the – the doctors in the – in the hospital?

A Generally not, no.

Q How would – how would a – a – a resident or a –, a doctor on staff at the hospital know that a particular policy has been changed?

A By going to the various committees and – and then by the people like myself informing them.

Q All right.

A You know, so it's part of my job. If something that I think they need to know about has been changed or revised or – then – then we would let them know.

Q Okay.

A But generally these type of things, if there's something that they really need to know about, then you might send it around to all the residents.

Q Okay.

A You know.

Q Let me ask you, Doctor, these two policies, one number 418 that indicates its [p. 15] discharge criteria from a critical care complex, number 420 indicates the subject is transfer of patients from the critical care complex to another facility, would – would these two policies be applicable to all discharges and transfers from the critical care complex at the University of Louisville Hospital?

A Yes. Now, that doesn't mean that every single thing is followed because, again, these are policy procedures which are general guidelines and – and – but – but they would be applicable, yes, to all the patients.

Q All right. Let me refer you to – to policy number 420 at – at this point. And if Wanda Johnson was transferred from the critical care complex on July 24 of 1992, would this policy have applied to – to her transfer at that time?

A Now, that – run that question by me again?

Q All right. If Wanda Johnson was transferred from the critical care complex –

A (Interrupting) Uh-huh.

Q (Continuing) – of the University of Louisville Hospital on June 24th of 1992 to another facility, would policy number 420 have been [p. 16] applicable to her transfer?

A Well, I assume it would if it was – already been approved and in place.

Q All right. In the fourth paragraph on that policy, the policy indicates that transfers can take place only after the transferring physician has received approval for the transfer by the patient or the patient's family and the accepting physician. As to the accepting physician, is it policy within the University of Louisville Hospital for – for the – the patient's physician at U of L to contact the physician at the other facility to receive acceptance of that patient?

A No, not necessarily. A lot of this is done – a lot of this is done through nursing and discharge planning, so it's not necessarily that we always talk with the referring physician. As a matter of fact, most of the time when I transfer patients, say, from University or Norton's or Jewish to Frazier, I will not personally have talked with the referring physician. Now, someone has and they are – you know, they are then about the patient, but it's not necessarily a – a physician-to-physician contact. It may be, it depends on the situation.

[p. 17] Q Now, you've been referring to – you've been saying the referring physician. Are we talking about the physician who's going to be treating the patient at the receiving facility?

A Well, that would be the – the – no, the referring physician would be the patient – the – the physician who's sending the patient. So if I were the referring physician, I may or may not talk with – directly with the physician to whom I'm going to send the patient. I might, but I might not.

Q All right.

MR. THOMPSON: Let me make sure – I think we're getting confused here and I want to make sure everybody's talking apples and apples and not apples and oranges. You're talking about transferring a patient to –

A (Interrupting) Another facility.

MR. THOMPSON: For critical care or acute care or to a skilled nursing home?

A Either – either one. If it's a skilled nursing home, then I almost never talk with the – almost never talk with the physician that's going to take care of the patient.

Q Okay. The policy refers to the [p. 18] accepting physician and I assume that's – we're –

A (Interrupting) Right.

Q Who we're talking about here –

A (Interrupting) Right.

Q (Continuing) – at this receiving facility?

A Uh-huh.

Q Even though a contact between the physician at U of L and the accepting physician is not always made physician to physician, is the policy that someone is supposed to contact the accepting physician to have that patient accepted? Is that what this policy says?

A Well, to be honest, I mean, I – pol – there's policies for everything and so I sure – I read these, but I sure don't memorize them and know them all by heart. So –

MR. THOMPSON: (Interrupting) Doctor, why don't you take a minute and read that carefully before you testify about this?

A Yes. Right. Transfer – let's see. Fourth one, transfers will be made using good medical practice and for the benefit of the patient. No patient – patient – wait.

MR. THOMPSON: Excuse me, Doctor.

[p. 19] Q Fifth. Fifth.

MR. THOMPSON: Would you mind – A (Interrupting) I'm sorry, it's the next one.

MR. THOMPSON: Would you mind just starting at the top and read to yourself and make sure you understood what this applies to?

A Okay. Okay.

Q All right. My question, again, is – is in reference to the fifth paragraph –

A (Interrupting) Uh-huh.

Q (Continuing) – on this particular policy. And my question to you is: Would it be consistent with the policy of the University of Louisville as evidenced by policy number 420 that when a patient is transferred from a critical care complex to another facility that the physician or someone on the staff is to contact the accepting position – physician to verify his acceptance of the patient?

A Generally that would be – that would be true and it would – it would depend a lot on the condition of the patient and where the patient was going. If the patient is going to a hospital, then you – almost always someone

would contact – would [p. 20] contact that – would contact that – that physician who's going to be taking care of that – that patient. If the patient is going to a rehab center or if the patient's going to a nursing home, then generally we would not. Now, most of the time when patients – the majority of the time when patients go from our facility to a nursing home or a rehab center, they're not coming from a critical care complex but occasionally they do. So according to this policy, what it says is that – that the – that they would – they have received approval by the accepting physician, but that doesn't mean that we would necessarily make contact or talk with them. We would sure have to make contact or talk with someone in that facility that's – that sort of takes the authority and the responsibility for saying yes, our facility can take care of this patient.

So we would – we would assume unle – if we did not think we needed physician-to-physician contact or directly to talk with that physician, that – that's been done by the – by the person, whoever it is that we contact. And usually most of the time this is done by social service and [p. 21] discharge planning and – and not by the physician.

Q All right. You've indicated that – that you – someone talks to the facility, but again, reviewing paragraph five there, doesn't it indicate that the policy is that – that someone at least has to receive approval from the accepting physician?

A Right. And we're assuming that – that their representative that we deal with from that facility has done that.

Q All right.

A I mean, we can't – if – if the patient – again, it depends on the patient. It's – it's a judgment decision. If the judgment is that, boy, this is not good enough and we need to talk with the doctor – doctor about it or it may be that, boy, this isn't good enough and our doctors need to talk with their doctors. So it all depends on – it all depends on – on the individual patient.

Q All right. The next paragraph in that policy indicates that the critical care complex will secure a written, informed consent prior to transfer, and then lists some things that the – that the consent is to – is to include. Is that

* * *

[p. 27] Q Would you read the second paragraph of the purpose for policy 420, rule 420?

A To assure that all patients who have an emergency medical condition are transferred in accordance with the COBRA requirements.

Q Does this policy, then, apply to patients who, in fact, have an emergency medical condition?

A Yes.

Q Would it be unusual or inappropriate – strike that. Would it be inappropriate to transfer a patient who has an emergency medical condition to a nursing home?

A No, it would not be appropriate.

Q Is it your opinion, do you have an opinion whether this policy would apply to patients who are being discharged in a stable condition to a nursing home?

A I –

MR. MATTINGLY: (Interrupting) Before you answer, Doctor, let me object to his opinion rendered about Wanda Johnson or a patient in general using the terminology that you're using, because I think all of those are – are – are legal terms rather than medical at this point, and Doctor Miller [p. 28] has not been identified as an expert witness to provide his opinions in this case as to the appropriateness of a transfer.

Q Doctor, you – you did rounds on this patient, Wanda Johnson, did you not?

A Yes. I saw her several times in ICU.

Q The residents, medical students who were taking care of her, were they under your supervision?

A To some extent, yes.

Q You were the chief of the –

MR. TANNER: (Interrupting) Intensive care.

Q You were chief of surgery –

A (Interrupting) Yes.

Q (Continuing) – correct? This was a surgical patient?

A Yes.

Q You were also the chief of the surgical intensive care unit where she was a patient?

A Right. Yes.

Q All right. And you sat on the committee that was involved in promulgating policy 0420, correct, sir?

[p. 29] A Yes.

Q For the – for the patient, Wanda Johnson, who was being cared for by your students and residents on the floor where you were the acting chief, did this policy apply – would it have applied to Wanda Johnson?

MR. MATTINGLY: Objection. Question's already been asked and answered.

Q Go ahead.

A Well, it – I think that's a matter of opinion. These are general guidelines for patients in our critical care units and – but – but – so as – in terms of that she was in our critical care unit. So the guidelines would – would – would apply as general guidelines, but to say that everything here applies to Wanda Johnson, almost – medicine is very complex and there's hardly any patient where you can write a guideline where the guidelines always apply to that patient. I mean, they're guidelines.

Q And this policy applies to patients in the critical care complex?

A Yes.

Q And it applies to those patients who have an emergency medical condition, correct?

[p. 30] A Yes.

Q Did she on July 24, 1992, based upon your review of the record, have an emergency medical condition?

MR. MATTINGLY: Objection.

A In my opinion –

MR. MATTINGLY: (Interrupting) Let – let me – I'm gonna let you answer, but let me object again, because he has not been identified as an expert. The time for identifying experts has already passed. He's – he's here as a fact witness only and – and we would object to the giving of any opinions concerning Mrs. Wanda Johnson's condition.

Q Go ahead, Doctor.

MR. MATTINGLY: Go ahead and answer.

A In my opinion, she did not have an emergency medical condition on the date of her trans'er.

Q Doctor, did – did the physician who discharged Wanda Johnson on July 24, 1992, in your review of the records, was that discharge appropriate?

A Yes.

Q Doctor, in – in your role as a chief of the surgical intensive care unit and chief of [p. 31] department of surgery, if a patient was discharged from this facility who – who should not have been char – discharged based upon the patient's medical condition but was discharged solely because of a financial reason, would that be brought to your attention?

A Well, I would hope so. And I would – I would say yes. I have never known that to have happened, but I would assume and hope that it would be brought to my attention, yes.

Q Based upon your knowledge of this patient and your review of the records and your – and your position as a chief of department of surgery and chief of the surgical intensive care unit, are you aware whether this patient was discharged or whether her financial circumstances played any role at all in her discharge from this facility?

A Well, the on – I can say something as a general policy. Basically the attendings and the residents never have any idea what the financial condition of the patient is. Now, we almost never know that and, as a matter of fact, for most of our trauma patients, the hospital really doesn't even know it, especially because so much of their – [p. 32] their reimbursement really is an unsettled issue for months and months because so many of 'em are accidents and injuries. And especially motor vehicle accidents, where you don't know even if the patient has no money or no insurance. Many times three months later, six months later you find out that the other party has insurance that covers them or – or – or it is gonna be work related or there's a lawsuit involved in terms of negligence and creating the injury and somebody else pays for it.

So – so we – as an attending physician and – and as a – as a resident, we almost never find out who has – who has insurance and who doesn't and – and – and what the pay status is.

Q And certainly, at least to this date, no one's made you aware that Wanda Johnson's discharge from this hospital was motivated in any way by her financial circumstances?

A I cannot imagine that it was.

Q Okay. But my question was: Has anyone ever made you aware of that?

A No, no one's ever made me aware of that.

[p. 33] Q No resident or attending's come to you, said, "Doctor, the hospital is telling me to get this patient out of here because she doesn't have money to pay for her care"?

A The hospital never does that. Not this hospital.

Q Go back briefly to policy 0420 and I'm just about finished here. If a patient was sub – had an emergency medical condition and was being transferred from this hospital to another facility, I take it it would be important that there be communication with the physician who's going to be rendering care for that emergency medical condition?

A Yes.

Q And is that basically what this policy's dealing with, Doctor?

A Well, I think that's a lot to do with how – what this policy is dealing with, yes.

MR. THOMPSON: Anything else? (Whereupon Mr. Thompson and Ms. Tanner conferred out of the hearing of the reporter.)

MR. THOMPSON: Doctor, I think that's all I have.

MR. MATTINGLY: Doctor, just a couple follow-up questions.

[p. 34] REEXAMINATION

By Mr. Mattingly:

Q Referring again to policy 0420, Mr. Thompson has directed your attention to the second paragraph of the purpose statements on that policy, but there is a second purpose identified there also, is there not?

A Yes.

Q All right. And that purpose indicates that the policy is to provide guidelines for the safe and efficient transfer of patients from the critical care complex to another facility. Isn't that the second purpose for this policy?

A That's another purpose.

Q All right. You testified earlier that in all likelihood, you were on vacation at the time that Mrs. Johnson was discharged from the hospital; is that true?

A Yes.

Q And other than possibly a review of Mrs. Johnson's medical records, you had no involvement in the discharge plan or the actual discharging of this patient, did you?

* * *

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF KENTUCKY
LOUSIVILLE DIVISION

CAUSE NO. C-93-0544-L-M

[Caption Omitted In Printing]

* * *

The deposition upon oral examination of **JOHN W. STUY, M.D.**, * * * on March 28, 1995, * * *

* * *

[p. 13] (EXAMINATION – BY MR. THOMPSON)

The bronchoscope can be very helpful, too, in trying to clear areas of blockage so that someone can clear secretions better. You can use it also to obtain cultures to help guide your therapy, if someone isn't responding to therapy.

Q. And are you aware of, do you know whether there were earlier chest X-rays taken?

A. She had several chest X-rays taken during her stay at Humana.

Q. Are you able to say as of July 23, 1992, the day of the first of the two reports that were provided to you, where it says that the right upper lobe atelectasis and/or atelectasis, which you think was infiltrate –

A. Right. That's what they meant.

Q. – do you know to what degree it had improved by this point?

A. They don't comment on it. I looked at the films myself, and I mean, I think I see some subtle improvement. I

would be hard pressed to quantitate it. I would have to put it [p. 14] back up on screen and try to quantitate it in terms of percent, if that's what you are looking for.

Off the top of my head, I wouldn't want to speculate without looking at the films. But I agree with the report. I did think there was some improvement.

Q. There was some improvement from the July 24 film compared to the July 23 film; correct?

A. Right.

Q. When you say some improvement, what are you comparing it to?

A. What I'm looking for is the size of the infiltrate and/or atelectasis. And it appeared to be a little bit smaller on the 24th compared to the 23rd. That's what I meant, and I assume that's what they meant as well.

Q. Any other materials that you were provided since your January 25, 1994 deposition?

A. I received a copy of my deposition, which I remember skimming over, uh-huh.

Q. Anything else?

* * *

[p. 23] platelets more than the white blood cells that would be affected.

Q. You have discharged patients from hospitals with a urinary tract infection, either to home or to a skilled nursing facility; right?

A. Yes.

Q. In discharging a patient home with a urinary tract infection, what type of treatment do you prescribe for that?

A. Typically an antibiotic, something perhaps for the discomfort, and some instructions, and usually a follow-up urinalysis to be sure that the infection is clear a few weeks after therapy has been completed.

Q. If a patient were being transferred or discharged to a skilled nursing facility, the same type of medications you would expect to be given to them, and would there be some follow-up at the skilled nursing facility?

A. Most all nursing homes that I'm aware of, if a patient arrives on any sort of an [p. 24] antibiotic therapy, wi11 have their blood pressure, pulse and temperature checked at least every shift. And usually, again, you would ask for a follow-up urinalysis after completion of therapy. And most nursing homes would ask for that if the transferring doctor didn't ask for that himself.

Q. Skilled nursing facilities, you would expect them to have personnel trained who could take vital signs; correct?

A. Of course.

Q. You would expect the nurses at a skilled nursing facility to know to call a patient's physician if signs and symptoms are found that are indicative of a deterioration of the patient's condition?

A. I would expect that, yes.

Q. Do skilled nursing facilities in the Indianapolis area, has it been your experience that they have the

capability to obtain urine cultures or other lab work for patients if ordered by a patient's physician?

[p. 25] A. Yes.

Q. Would that be true for Crestview Nursing Home in 1992 to your knowledge?

A. I've never worked with Crestview, but I would assume that they could do that. Otherwise, they wouldn't remain accredited.

Q. Who accredits nursing homes, by the way?

A. The state will inspect nursing homes. There are state and federal guidelines that have to be met.

Q. Do you know which branch or agency of the state licenses nursing homes?

A. Gosh, I don't remember offhand, no.

Q. Is there a health board or something?

A. Yes.

Q. Is that different from the agency that would license nursing homes, or do you know?

A. I don't know, either.

Q. Would you expect, back to the urinary tract infection, would you expect that a skilled nursing facility would be able to manage and care for a urinary tract infection?

A. Yes.

* * *

[p. 28] brought to my attention a few months ago.

Q. You can be a patient who is eligible for Medicaid benefits and have requirements of skilled nursing care, and those requirements aren't lessened at a nursing home just because a patient was Medicaid versus Medicare?

A. They are not supposed to be.

Q. I'm skipping around on you a bit here. I apologize for that.

A. That's all right.

Q. In terms of this urinary tract infection we were discussing a moment ago, pending the results of a culture and sensitivity test, broad spectrum antibiotics typically are initiated for the patient pending those results; is that correct?

A. You would pick an antibiotic to cover the expected organisms, that's right.

Q. We've already talked earlier and said the antibiotic they placed Wanda Johnson on at the time of her discharge was a reasonable antibiotic?

[p. 29] A. In my opinion, yes.

Q. If you discharged a patient from your hospital on a broad spectrum antibiotic, awaiting the culture and sensitivity report, and you got that report back, and it indicated that the causative organism was resistant to the antibiotic you prescribed, would you simply change that patient's prescription?

A. I would contact the facility, yes, and change her antibiotic.

Q. Yes. You wouldn't have her brought back up and examine her. You would simply change the medication she was on to an antibiotic that would address that organism?

A. Assuming she is not having difficulty, yes.

Q. Right, assuming she's not having difficulty. If Ms. Johnson had remained at Crestview after her initial transfer there and had not had a complication that required her to come to the emergency department – are you with me so far?

A. Uh-huh.

• • •

[p. 32] speculate what I think was the source of it, but I don't know for a fact.

Q. Well, let me ask you, have you reviewed the records at Crestview?

A. Yes, uh-huh.

Q. Do you have an opinion within a reasonable degree of medical probability as to what caused her condition to deteriorate from the time of discharge until she was transferred?

A. Either the urinary tract infection that she was treated for was not covered, was not sensitive to the antibiotic that she was sent on transfer, or she developed another acute pulmonary infection.

Q. Have you reviewed the nursing care that was rendered to Ms. Johnson at Crestview in terms of whether she was appropriately –

A. I reviewed the nursing notes, yes. You showed me those notes, also, at the first deposition.

Q. Right. Do you have an opinion whether Ms. Johnson was adequately monitored by the nurses at Crestview Nursing Home?

• • •

[p. 61] home may need to manage the urinary tract infection?

A. Or pneumonia.

Q. Or pneumonia because both of those had been recurring throughout her hospitalization at Midwest; correct?

A. That's correct.

Q. Assuming you were satisfied with the nursing home and its ability to handle Wanda Johnson, you were going to transfer her, knowing that she could develop a urinary tract infection or pneumonia while in that facility?

A. That's correct. If they are capable of managing it, then I would transfer.

Q. Right. I understand. But just so I'm clear on this, just because she had a risk for the, a high risk for urinary tract infection and pneumonia, that did not mean that she needed to remain in your hospital or some other acute care facility?

A. That's correct.

Q. I'm getting close to the end here, if that

• • •

[p. 79] problems." And she said, "Yes. No, we've never taken care of someone this complex at this facility."

That's what I was told. And again, I know you had asked me this before, I did not have the name of the nurse that I spoke to. But again, there were only so many nurses on duty on a Saturday morning; so you should be able to sort that out.

Q. This is a nurse at Crestview?

A. Right. I tried to get some information about the patient from the facility.

Q. Would you expect a nursing home, if it had never taken care of a patient such as Wanda Johnson, would you have expected Crestview to be up front about that with the social workers at the University of Louisville Hospital?

A. Yes.

Q. And tell them, We've never done this before. We've never had a patient this complex in our nursing home.

A. I would expect them to say so, yes. I would [p. 80] expect the social worker at Humana to ask those questions, too.

Q. You would expect to get truthful answers from the representative of Crestview; correct, sir?

A. That's correct.

Q. To the extent it is a licensed facility, to the extent it is certified by the state, you would expect you would

not have a problem if a social worker got answers from that nursing home and relied on those answers?

A. No, I wouldn't have a problem if they felt they were getting truthful answers. What else can you do when you talk to people?

Q. Okay. And you would certainly expect that if a nurse had gone to the administration of that nursing home and said, "I do not think we can take care of this patient," that a decision to accept that patient because the facility wants the revenues, that that would be egregious?

A. Terrible.

Q. Terrible. Thank you.

• • •

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

CIVIL ACTION NO. 93-0544-L(S)

[Caption Omitted In Printing]

The deposition of WALID A. ABOU-JAOUDE, MD, taken pursuant to notice by the Defendant on March 31, 1995.

* * *

[p. 15] appropriate antibiotics to treat her pneumonias and her urinary trace infections.

She was pretty much stable for the time that I took care of her, and probably a couple weeks before her discharge, she was transferred to a step-down unit, which is the eighth floor. It's part of the ICU, but it's less intensive. And she progressed slowly. She made some improvement.

By system, neurologically, she was impaired when we first started the service. She had flaccid paralysis, the etiology we were not sure of. We had neurosurgeons following her as well. And we were not sure which way she's going to go, but neurologically she made some improvement in the time that I took care of her, that at the time of discharge, at least she was gazing a little bit and shrugging her shoulders, which she didn't have before.

Respiratory wise, she had multiple pneumonias, but again she responded to the antibiotics. And she was a

high-care patient in the sense that she required pulmonary toilet frequently and she – she required bronchoscopies, which is part of our pulmonary toilet protocol at the university. And again she progressed and we were [p. 16] able to get her off the ventilator, which was a big improvement at that time.

Gastrointestinal, I mean, she was feeding with the Dobbhoff tube placed in, but she wasn't eating, taking anything orally, and she was doing well with that. Prior to the time I took care of her, she had episodes of pancreatitis and upper GI bleeds, but all of these subsided by then. Neurologically, she had the indwelling Foley catheter, and if I recollect, she had about –

THE REPORTER: (Interrupting) She had –?

A About with yeast infection in the urine that responded to amphotericin, A-M-P-H-O-T-E-R-I-C-I-N, irrigation. And again she had urinary tract infections, again responded to antibiotics.

Otherwise, she was receiving rehabs and routine exercises. And we had speech therapy evaluate her. We had all the services in the hospital, as far as speech and rehab and respiratory work, with us in managing this patient. But as far as I recoilect, I mean, she went through the worst period of time prior to July.

[p. 17] Q Uh-huh.

A By July she was pretty much on a steady course of showing improvement.

Q Let me ask you, Doctor, you – you mentioned a couple of times that at the point when you began treating this patient in July, she appeared to be stable. Can you

define to – for me what – what you mean by appeared to be stable?

A By stable I mean that she was not acutely deteriorating or sick.

Q During that period of time, were there instances where she did have this recurring pneumonia?

A She did.

Q And during that same period of time, were there instances where she had this recurring urinary tract infection?

A She did.

Q Would those have been instances where – where the patient became less stable than – than she was at the beginning of the period of time when you began caring for her?

A Her pneumonias and her urinary tract infections did not put her in a position of instability. I mean, we were able to detect them

* * *

[p. 19] approach the social workers until we know that the patient is in a condition where she can be transferred, is stable enough to be transferred.

Q Doctor, have there been occasions while you were a resident at the University of Louisville Hospital where you had notified the social services department that a patient had become stable enough to transfer and requested that they begin looking for a placement, but

that at some point subsequent to that, the patient's condition deteriorated to such an extent that you had to delay transfer?

A Offhand, I cannot recollect a patient.

Q That's possible that that could happen, though, isn't it?

A It is possible.

Q Do you recall specifically in Wanda Johnson's case what involvement you had in discussions with the social services staff in their attempts to place Wanda?

A I recall that the social working – the social worker working at that time on the case, Nancy Fred, we approached her that Wanda is making progress and we need to look for a place for her to go following her discharge from the hospital.

[p. 20] And we made – at that time, when we approached Nancy, the pen – the patient was still on the ventilator, and we were looking for a nursing home that can provide ventilator equipment and nursing skills that can take care of the patients on ventilators, but – and that's what she started working on. But when Wanda made some improvement in her respiratory status and we were able to get her off the ventilator, we approached Nancy Fred again and we told her that now she's making progress, so we can look at a nursing home that has skilled care to take care of this patient now that she's off the ventilator.

So we approached her, it must have been a couple weeks before discharge, but the progress that we made

changed the course of her – the course of where she's going to, what nursing home.

Q You referred several times to we approached social workers. Were these social workers that you personally approached or was this someone else that was just on the surgical residency team that – that was talking to the social workers?

A Well, as a team on the trauma service, there's four people working on that team, and each [p. 21] has a different responsibility. There's a chief resident, chief resident, who is the last year surgical resident, and there is a third-year resident who takes care of the emergency room, and there's the second-year, or what we call the intensivist takes care of the ICU patients, and the first year. And depending on the patient you're taking care of, whether it's in the ICU or the floor, the patient respon – the – excuse me, the surgeon responsible of taking care of that patient approaches the social worker. But all of that is done in association with the chief resident.

Q All right. I guess my specific question, Doctor, is whether you personally had discussions with Nancy Fred about Wanda Johnson's discharge plan.

A I talked to her, to Nancy multiple times about the case, because I was familiar with it.

Q And – and the kinds of things that you discussed with Nancy included what?

A The first time I approached Nancy or –?

Q As best you can recall, the substance of any conversations that you had with Nancy about

* * *

[p. 29] of the conversation that you had with Nancy when you first learned that Crestview nursing home may be considering Wanda as a placement.

A Uh–huh. When Nancy Fred approached me with the fact that there is a nursing home, Crestview nursing home, that's willing to take this patient, we just wanted to make sure that it was skilled enough to take care of this patient. And like other nursing homes, they have a representative that comes to the hospital to visit the hospital, talk to the patient or the family and the nurses, and sometimes talk to us, as doctors, to see what's going on with her medical status, but that's been pretty much the routine. As far as Crestview, it was just part of the routine that we go through.

Q Do you recall ever talking to the representative from Crestview yourself?

A Approaching them first?

Q No. Well, no, speaking to them at any time prior to Wanda's discharge.

A No.

Q You mentioned that when Crestview was mentioned, you wanted to know that they could – they could adequately care for her, or properly?

A Right.

[p. 30] Q Do you recall what types of questions you asked Nancy Fred – let me strike that and ask you, prior to Nancy Fred mentioning Crestview nursing home in

Wanda Johnson's instance, do you know if you had ever dealt with Crestview nursing home before?

A I don't think so.

Q What kinds of questions did you ask Nancy Fred or what kinds of information did you request to make you feel comfortable that this facility could handle Wanda Johnson?

A First of all, I wanted to make sure it was a skilled nursing facility in the sense that they can provide the skilled care for this patient. We were definitely concerned about her condition, because she was – she was very sick when she first presented, and she was making progress, and we wanted to make sure that there is a facility or people that can attend to – to her needs and make sure that she continues to make progress.

Q Do you remember whether or not you asked Nancy Fred if she knew if Crestview nursing home had ever cared for a patient who needed the level of care that Wanda Johnson needed?

A I don't remember that.

* * *

[p. 34] Q Do you remember whether or not you ever asked Nancy Fred – strike that.

Were you concerned at all when you learned that the facility that Nancy had located was in Indianapolis, Indiana?

A No.

Q Did you feel that its geographic location was satisfactory to accommodate the needs of Wanda's family?

A As I told you, I never had any contact with the family.

Q Fair enough. Fair enough.

A Can I add something?

Q Certainly.

MR. THOMPSON: Sure.

A I mean, I never had any contact with the family because I could not reach the family. I could not reach them myself. I mean, we tried multiple times to get ahold of the family, but we could not get ahold of them, because I never saw anybody in the hospital to talk to and see, because I would like to get to know the family as well as the patient. So we depended a lot on the discharge planning to make the right calls to get ahold of the family so we know what's going on with her family.

* * *

[p. 37] her hospital – of her hospitalization at the University of Louisville?

A She was pretty much stable the – the whole time, or at least the last two weeks that we were taking care of her.

Q Did you actually dic – excuse me. Dictate the discharge summary for Wanda Johnson?

A Yes, I did.

Q All right. Let me –

MR. THOMPSON: (Interrupting) Before we get into that, can we take a two-minute break?

MR. MATTINGLY: Sure. (Whereupon a recess was had from approximately 2:22 to 2:42 p.m.)

Q Doctor, let me hand to you a document and let you take a look at that and ask you if you can identify that document.

MR. THOMPSON: Should I take these back?

MR. MATTINGLY: Pardon?

MR. THOMPSON: Should I take this back?

MR. MATTINGLY: No, I'm going to look at them again in a few minutes.

A I dictated that summary, but it's not

* * *

[p. 46] colon, and there are two dates there. Do you know what the two dates would have meant?

A No.

Q So you're – you're unsure of what the August 24, '92 date refers to on that discharge summary?

A I don't know what it – no.

Q Were you still in Louisville on August 24th?

A Yes, I was still on the trauma service.

Q Now, let's refer to what I think now we've marked as Number 4, which is – is the discharge summary that has been supplied by counsel for the hospital.

Could you explain to me how it came about that – that this discharge summary contained handwritten notes and – and what the purpose was for such an update?

A When I dictated the other one, that one (indicating), Number 3 –

Q (Interrupting) Uh-huh.

A (Continuing) – I had to update it before she went to – to the nursing home.

Q And why did you have to update it?

A Well, for one thing, I had to read it, [p. 47] make sure that they don't have any mistakes in it.

Q Uh-huh.

A And I filled in a couple blanks that were left, and then at the same time realized that we need to make sure that they know that she is on the T piece and that she's requiring the positive pressure ventilation.

Q DPs? What are DPs?

A On the T tube piece, T tube piece. It's just she's on a tracheostomy. She's on a 40 percent oxygen, which she was getting through the T tube. And if I recall correct, my chief resident asked me to specifically go over this and make sure that I mentioned that she is on that amount of oxygen and she's requiring that kind of pulmonary toilet as well –

Q (Interrupting) Okay.

A (Continuing) – before she got discharged.

Q All right. Any other changes that you felt necessary to make?

A Well, we started her on Bactrim, antibiotics, before she was discharged.

Q Okay. And why did you start her on Bactrim?

[p. 48] A Well, at that time, when she spiked a temperature –

Q (Interrupting) Uh-huh.

A (Continuing) – we worked her up for the fever, and which included – our workup included at that time a chest x-ray, urinalysis and – and a CBC, which is part of our routine workup for fevers. The urinalysis was cloudy and showed white blood cells in it that was elevated than previous analysis. She has a chronic indwelling catheter and she was predisposed to having colonizations and white blood cells in the urine, but that was elevated. At the same time, she had some bacteria that was not there in previous urinalysis. So we were suspecting a new urinary tract infection developing, and Bactrim is an excellent medication for that.

Q All right. Let me make sure I understand the time period that these – these events transpired or these changes in her condition occurred.

A Uh-huh.

Q You dictated a discharge summary on July 21st of 1992 that indicates that she was off antibiotics at that time, correct?

[p. 49] A Correct.

Q Now, is your testimony that from Jan – from July 21st, 1992 to July 24th, 1992, that – that she had spiked a temperature?

A She had spiked a temperature on the 23rd.

Q Okay.

A But during her hospital course, she was always spiking temperatures every so often. We – the cause of that, we – I mean, we would work her up, we would get the necessary urine specimen, x-rays and blood work to rule out any – any source of fever that we can identify and treat her, and that was just part of her course in the hospital, actually.

Q Would it be true that from July 21st, 1992 to July 24th, 1992, that Mrs. Johnson during that period of time developed a urinary tract infection?

A It could be possible.

Q You suspected that she had, did you not?

A Well, when she spiked the fever, we had – like I mentioned, we had the x-ray, we had blood – blood work and the urinalysis done. Our [p. 50] main concern was if she's developing a pneumonia or a urinary tract infection.

Q Uh-huh.

A And we wanted to work her up for – for both as a source of fever. And working up her urine – her UTI, urinary tract infection, we just send the urine and we – excuse me, and we know that that was cloudy, so we had a high suspicion. We didn't have the results of the urinalysis back then, but we could not wait 'til we get results back to treat the patient.

As far as her suspected pneumonia, we got a chest x-ray, and during her hospitalization she had some persistent infiltrate in the right upper lobe that was of concern to us, because it could – it – it would predispose her to having pneumonias, it would predispose her to having collapse, and that's why that night when she spiked, I remember I – I did a flexible bronchoscopy on her, which is part of our routine evaluation at University of Louisville, and we do the flexible bronchoscopy mostly to clear up the lungs from secretions, get rid of the plugs that can cause the lung to collapse.

And from reviewing my – my operative [p. 51] note, it looked like she had more secretions that we were able to suction with the bronchoscope more effectively than just with routine suctioning at that time, and that the – a specimen was taken and was sent to the lab just to make sure that she's not growing anything there that would turn into pneumonia. And the Gram's stain showed gram-positive cocci, which we don't get real worked up about it, because she has been in the intensive care unit for a while and she is prone to having colonizations from gram-positive coccis.

And – and empirically we just started her on Bactrim, because Bactrim has been used before to treat her bouts of pneumonia that she had and as well as it covers the urinary tract infection. So we felt that Bactrim would cover either one, not knowing exactly which one she had.

Q All right. And from the time that you took those – those cultures or – or specimens and submitted them to the lab, how long would it – would it have taken you to get the results back, generally?

A The urinalysis, we get it real quick. It takes sometimes an hour or two hours, but we get the results. We don't get the culture, because they [p. 52] have to plate it, it takes from 24 to 48 hours to get the specific organism that's growing. But at least we would get the urinalysis, microscopic urinalysis, which indicates how many white bloods cells, red blood cells, proteins, ketones, nitrites, leukocytes present in the urine, which would help us.

And then as far as the sputum culture or the bronchial specimen, the Gram's stain, it depends when you send it to the lab. Sometimes it can take overnight to get the results, but we usually get it within the next 12 hours or so. That would give us an indication of if there is anything nonspecific, either white blood cells or gram-positive rods, gram-negative rods, that's what we look for then. The culture can take from 24 to 48 hours, even more.

Q Do you recall whether you had received results back from any of these tests before Wanda Johnson was actually transferred from the hospital?

A Yes, we had the results of her urinalysis, and we had the results of the Gram's stain that was done on the bronchial specimen as well.

Q Do you recall when those tests were [p. 53] actually taken? Was it – was it the morning of the 24th or was it the day before it, if you recall?

A We did those when she spiked the temperature. That was the night of the 23rd.

Q And it's your recollection that you had those results back sometime the next morning?

A Yes. I documented them in my note the next morning.

Q Do you recall whether there was ever any discussion of holding Wanda for another couple of days until all of the results came back?

A Discussion among?

Q Among – between you and the social worker staff or between anyone else that you may have overheard.

A I presented the data to the chief.

Q Who is?

A Doctor Brian Harbrecht.

MR. THOMPSON: Spell the last name.

A H-A-R-B-R-E-C-H-T. He was the chief on the service at that time. And he was aware of those results before we even made the decision that morning to send her to the nursing home – nursing home.

Q Do you recall your specific

• • •

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

NO. C-93-0544L(CS)

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON **PLAINTIFF**

v.

AFFIDAVIT

GALEN OF VIRGINIA, INC. d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL **DEFENDANT**

• • •

Affiant, David Richardson, M.D., being duly sworn, states as follows:

1. I was the attending physician responsible for supervising surgical residents on the Trauma Team who cared for Wanda Johnson at University of Louisville Hospital in July, 1992.

2. I have held the position of attending surgeon at the University of Louisville Hospital for 18 years.

3. During that time, I have never known a patient to be discharged because of financial reasons.

4. In July, 1992, I participated in Wanda Johnson's medical care.

5. Wanda Johnson's condition was sufficiently stable to warrant discharge on July 24, 1992.

6. I am certain that Wanda Johnson's financial situation was not a consideration in the medical decision to discharge her from University of Louisville Hospital.

Further Affiant Sayeth naught.

/s/ David Richardson, M.D.
DAVID RICHARDSON, M.D.

COMMONWEALTH OF KENTUCKY)
) ss.
County of Jefferson)

Subscribed and sworn to before me by David Richardson, M.D., this 10 day of March, 1995.

My Commission Expires: 2-21-96

/s/ Anne Cunningham
Notary Public
State at Large

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

NO. C-93-0544L-(CS)

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — **PLAINTIFF**

v. **AFFIDAVIT**

GALEN OF VIRGINIA, INC. d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — **DEFENDANT**

* * *

Affiant, Walid Abou-Jaoude, M.D., being duly sworn, states as follows:

1. I was a second year surgical resident (intensivist) at University of Louisville Hospital in July, 1992.

2. I was responsible for the care of Wanda Johnson in July, 1992.

3. I wrote the order to discharge Wanda Johnson from University of Louisville Hospital in July, 1992.

4. In my opinion, Wanda Johnson's condition was medically stable on the day of her discharge from University of Louisville Hospital.

5. I was unaware of Wanda Johnson's financial status in July, 1992.

6. Wanda Johnson's financial status was not a factor in my decision to write the discharge order in July, 1992.

Further Affiant sayeth naught.

/s/ W. Abou-Jaoude
WALID ABOU-JAOUDE, M.D.

STATE OF PENNSYLVANIA)
) ss.
County of)

Subscribed and sworn to before me by Walid Abou-Jaoude, M.D., this 15 day of March March, 1995.

My Commission Expires: _____

/s/ Marcelle Didiere-West
Notary Public
State at Large

[Seal]

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

NO. C-93-0544L-(CS)

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — **PLAINTIFF**

v. **AFFIDAVIT**

GALEN OF VIRGINIA, INC. d/b/a UNIVERSITY OF LOUISVILLE HOSPITAL — **DEFENDANT**

* * *

Affiant, Brian Harbrecht, M.D., being duly sworn, states as follows:

1. I was the Chief Resident at University of Louisville Hospital in July, 1992.

2. As Chief Resident, I was responsible for supervising intensivists at Humana Hospital University of Louisville.

3. I was consulted in and approved of Wanda Johnson's discharge from University of Louisville Hospital in July, 1992.

4. Wanda Johnson's condition was sufficiently stable to warrant her discharge, which was medically reasonable.

5. Physicians are typically not aware of a patient's payment source at the time of discharge.

6. Wanda Johnson's financial status played no part in the decision to discharge her from University of Louisville Hospital on July 24, 1992.

Further Affiant Sayeth naught.

/s/ Brian G. Harbrecht
BRIAN Harbrecht, M.D.

COMMONWEALTH OF KENTUCKY)
) ss.
County of Jefferson)

Subscribed and sworn to before me by Brian Harbrecht, M.D., this 7th day of April, 1995.

My Commission Expires: June 17, 1995

/s/ Kristina K. Micholovich
Notary Public
State at Large

[SEAL]

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

NO. C-93-0544L(CS)

JANE ROBERTS, as Guardian for WANDA Y. JOHNSON — **PLAINTIFF**

v. **AFFIDAVIT**

GALEN OF VIRGINIA, INC. d/b/a UNIVERSITY OF LOUSIVILLE HOSPITAL — **DEFENDANT**

* * *

Affiant, Nancy Fred, MSW, being duly sworn states as follows:

1. I was the medical social worker at University of Louisville Hospital who was responsible for Wanda Johnson's discharge planning in July, 1992.

2. Pursuant to a physician's order, I made discharge arrangements for Ms. Johnson.

3. Because of a long-standing shortage of nursing home beds in Kentucky, Indiana nursing facilities were considered for Ms. Johnson.

4. At the time of Ms. Johnson's discharge, her fee status was "Medicaid pending."

5. I was under no pressure from any department of the hospital or physician to locate a nursing home placement for Wanda Johnson for financial reasons.

6. I have never received any pressure from any department of the hospital or any physician to locate a

nursing home placement for any patient for financial reasons.

7. I did not inform Joanna Nolte, the marketing representative from Crestview Health Care Center, that I was under pressure from any department of the hospital to locate a nursing home placement for Ms. Johnson for financial reasons.

8. As a medical social worker I have no authority to discharge a patient from the hospital.

9. The decision to discharge a patient is made by a physician based upon the patient's medical condition.

Further the affiant sayeth naught.

/s/ Nancy Fred, MSSW
Nancy Fred, MSW

COMMONWEALTH OF KENTUCKY)
:SS
COUNTY OF JEFFERSON)

Subscribed and sworn to before me by Nancy Fred, MSW, this 1st day of May, 1995.

My commission expires: July 26, 1996

/s/ Millicent A. Tanner
NOTARY PUBLIC
STATE AT LARGE,
KENTUCKY

Supreme Court, U.S.
FILED
JUL 23 1998
OFFICE OF THE CLERK

No. 97-53

In The

Supreme Court of the United States

October Term, 1997

JANE M. ROBERTS,
Guardian for Wanda Y. Johnson,

Petitioner,

vs.

GALEN OF VIRGINIA, INC., Formerly d/b/a
Humana Hospital – University of Louisville,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF OF PETITIONER

JOSEPH H. MATTINGLY III
104 West Main Street
P.O. Box 678
Lebanon, Kentucky 40033
Telephone: (502) 692-1718

Counsel of Record for Petitioner

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

50 pp

QUESTION PRESENTED

Whether a claim under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, requires proof of an improper motive on the part of the hospital, its staff or physicians as a prerequisite for recovery.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF AUTHORITIES iii

OPINIONS BELOW 1

JURISDICTION 1

STATUTORY PROVISIONS INVOLVED 1

STATEMENT OF THE CASE 2

SUMMARY OF THE ARGUMENT 14

ARGUMENT 17

PROOF OF IMPROPER MOTIVE ON THE PART OF THE HOSPITAL IS NOT A PREREQUISITE FOR RECOVERY IN A CLAIM UNDER THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT, 42 U.S.C. § 1395dd 17

A. The Plain Reading of the Statute Compels the Conclusion That Improper Motive is Not a Required Element of an EMTALA Transfer Violation Claim 17

B. Proof of an Improper Motive to Establish a Claim Under EMTALA Has Been Expressly or Implicitly Rejected By Every Circuit Court of Appeals Which Has Considered the Issue 28

CONCLUSION 34

STATUTORY APPENDIX A1

TABLE OF AUTHORITIES

Page

CASES

Brooker v. Desert Hosp. Corp., 947 F.2d 412 (9th Cir. 1991) 19

Brooks v. Maryland General Hosp., Inc., 996 F.2d 708 (4th Cir. 1993) 19

Burditt v. U.S. Dept. Of Health and Human Services, 934 F.2d 1362 (5th Cir. 1991) 16, 28, 29

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 26

City of Chicago v. Environmental Defense Fund, 511 U.S. 328 (1994) 25, 26

Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990) 18, 19, 22, 29, 32

Collins v. DePaul Hospital, 963 F.2d 303 (10th Cir. 1992) 19

Correa v. Hospital San Francisco, 69 F.3d 1184 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996) 32

Eberhardt v. City of Los Angeles, 62 F.3d 1253 (9th Cir. 1995) 33

Gatewood v. Washington Health Care Corp., 933 F.2d 1037 (D.C. Cir. 1991) 19, 30, 32

Holcomb v. Monahan, 30 F.3d 116 (11th Cir. 1994) 33

Keene Corp. v. United States, 508 U.S. 200 (1993) 26

Marshall v. East Carroll Parish Hosp. Serv. Dist., 134 F.3d 319 (5th Cir. 1998) 33

Martin v. OSHRC, 499 U.S. 144 (1991) 26

McDonnell-Douglas v. Green, 411 U.S. 792 (1973) 27

TABLE OF AUTHORITIES – Continued

Page

Power v. Arlington Hosp. Ass'n, 42 F.3d 851 (4th Cir. 1994) 18, 30, 32

Repp v. Anadarko Mun. Hosp., 43 F.3d 519 (10th Cir. 1994) 33

Roberts v. Galen of Virginia, Inc., 111 F.3d 405 (6th Cir. 1997) 22

Smith v. Richmond Memorial Hospital, 243 Va. 445, 416 S.E.2d 689 (1992) 18

Texas Dept. of Community Affairs v. Burdine, 450 U.S. 248 (1981) 27

STATUTES

28 U.S.C. § 1254(1) 1

42 U.S.C. § 1395dd 1, 17

42 U.S.C. § 1395dd(a) ..... *passim*

42 U.S.C. § 1395dd(b) 16, 23, 28

42 U.S.C. § 1395dd(b)(1) 12, 20

42 U.S.C. § 1395dd(b)(1)(A) 12

42 U.S.C. § 1395dd(c)(2) 12, 21

42 U.S.C. § 1395dd(d) 12, 25

42 U.S.C. § 1395dd(d)(3) 12, 26

42 U.S.C. § 1395dd(d)(3)(A) 12

42 U.S.C. § 1395dd(e)(1) 12, 20

42 U.S.C. § 1395dd(e)(3)(A) 12, 20

42 U.S.C. § 1395dd(e)(3)(B) 12, 21

TABLE OF AUTHORITIES – Continued

Page

42 U.S.C. § 1395dd(e)(4) 12, 21

42 U.S.C. § 1395dd(e)(4)(A) 12

42 U.S.C. § 2000 26

42 U.S.C. § 2000e-2(a)(1) 26, 27

Ky. Rev. Stat. § 387.530 9

Ky. Rev. Stat. § 387.740 9

PUBLICATIONS

Paul Starr, *The Social Transformation of American Medicine* (1982) 18

Trieger, Note, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U.L. Rev. 1187 (1986) 17

MISCELLANEOUS

131 Cong. Rec. S. 13,904 (Daily Ed. Oct. 23, 1985) 25

59 Fed. Reg. 32,086, 32,104 (1994) 26

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit is reported at 111 F.3d 405 (6th Cir. 1997) and is reprinted in the Appendix of the Petition for Writ of Certiorari previously filed herein at A1-A25. The two opinions of the United States District Court for the Western District of Kentucky are not reported but are reprinted in the Appendix to the Petition for Writ of Certiorari at A26-A45 and A48-A52, respectively.

JURISDICTION

The order of the United States Court of Appeals for the Sixth Circuit was entered on April 9, 1997 affirming the order of the United States District Court for the Western District of Kentucky which granted summary judgment in favor of the Respondent. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The statute involved in this case is the "Emergency Medical Treatment and Active Labor Act," 42 U.S.C. § 1395dd, reprinted in the Appendix to this Brief and in the Appendix to the Petition for Writ of Certiorari at A55-A65.

STATEMENT OF THE CASE

The Petitioner, Wanda Y. Johnson (hereinafter "Johnson"), is a 40 year old mother of one child who was run over by a truck while walking home from her job as a cashier for Hardees Restaurant in Bardstown, Kentucky, late on the evening of May 19, 1992. (Deposition of Wanda Johnson, hereinafter "Johnson Depo., R. 50" at 17-18)[1]. She was flown from Bardstown to the Respondent's facility, Humana Hospital – University of Louisville (hereinafter "Humana") where she was diagnosed with serious fractures to her pelvis, right leg and four vertebrae of her spine as well as a brain injury. (Deposition of Walid Abou-Jaoude, M.D., hereinafter "Abou-Jaoude Depo., R. 67" at Exhibit 2). Johnson underwent exploratory surgery upon admission to Humana during which her spleen was removed. (*Id.*). A tracheostomy was surgically inserted into her neck and she was hooked to a ventilator to support her breathing. (*Id.*). Johnson's medical condition remained volatile throughout her hospitalization at Humana as she experienced numerous complications, including recurrent urinary tract infections and multiple pneumonias. (J.A. at

[1] References to items contained in the Joint Appendix are designated "J.A." with the page in the Joint Appendix where the item may be found. References to items contained in the Appendix to the Petition for Writ of Certiorari are designated "P.A." with the page in the Petition's Appendix where the item may be found. Relevant portions of deposition testimony not reproduced in the Joint Appendix are referenced to the specific deposition transcript and page number and docket number in the Record where the particular transcript may be found, i.e., "R. 50" would refer the Court to docket entry 50 to find the transcript of Wanda Johnson's Deposition.

116-117, *id.* at 14-15). Her hospital course was further complicated by fever and overwhelming infection with an elevated temperature to as high as 108 degrees. (Abou-Jaoude Depo. at Exhibit 2). During her hospitalization, Johnson's neurologic status deteriorated to a state of flaccid quadriparesis. (J.A. at 116, *id.* at 15). Despite Humana's treatment, Johnson's temperature spikes could not be controlled and the episodes of pneumonia and urinary tract infection continued through the last hours of her hospitalization. (J.A. at 126-128, *id.* at 49-50; Exhibit 2).

Despite the volatility of her condition, in early July, 1992, Johnson's physicians requested that the social services department at Humana begin making contacts with rehabilitation facilities and nursing homes to explore potential placement for Johnson if and when her condition was stabilized and she was ready to leave an acute care setting. (J.A. at 118-120, Abou-Jaoude Depo., R. 67 at 18-20; Deposition of Michele Weaver, R. 45 at 8).

The social workers who work at Humana are employed directly by Humana. Their job includes making placement at nursing homes and rehabilitation facilities for Humana patients who will not be able to return home following their hospitalization. (Deposition of Nancy Fred, hereinafter "Fred Depo., R. 10" at 4-5). The social workers are also called upon to seek legal intervention for patients who are incapable of independent decision making. (*Id.* at 5).

Humana's social workers immediately experienced difficulty in their efforts to find potential placement facilities for Johnson. The social workers learned that Johnson's husband had abandoned their five year old son and was cohabitating with another woman in Springfield, Kentucky. (*Id.* at 14-15, 23). Although the husband occasionally called the hospital, he would not leave a telephone number or contact location which was reliable enough for the social workers to maintain a consistent dialogue in developing a discharge plan. (*Id.* at 23-24). Furthermore, Johnson's mother was elderly and was herself ill and unable to function independently. (*Id.* at 23). No other close family member existed to provide assistance to the Humana social workers in developing a discharge plan for Johnson. Jane Roberts, Johnson's aunt, occasionally visited the hospital and attempted to locate Johnson's husband for the social workers. (J.A. at 19; *id.* at 24-25). However, Roberts had not been appointed as Johnson's guardian at that time and did not have the legal authority, nor had she been requested, to act as Johnson's surrogate decision maker. (Deposition of Jane Roberts, hereinafter "Roberts Depo., R. 51" at 21).

When Humana's social workers began their search for a placement for Johnson, she still could not breathe without assistance of a mechanical ventilator. (Fred Depo., R. 10 at 11-12). The ventilator dependency limited placement options. (*Id.*). However, days before her discharge, Humana unhooked Johnson from the ventilator and Humana's social workers contacted Chandler Nursing Home near Evansville, Indiana on July 20, 1992 as a possible placement facility. (J.A. at 19-23; *id.* at 25-28). Based on clinical information provided by Humana,

Chandler Nursing Home accepted Johnson conditioned upon on-site evaluation and approval by its Director of Nursing. (*Id.*). However, on July 22, 1992, only hours before the planned transfer, Chandler's Director of Nursing rescinded the nursing home's acceptance of Johnson following her personal evaluation. (J.A. at 23; *id.* at 28). Although Chandler was licensed as a skilled facility, its Director of Nursing determined that Johnson's condition was too serious for the facility to provide adequate care. (J.A. at 23-24; *id.* at 29). Chandler's decision to deny Johnson's placement was an obvious setback for Humana's social workers. However, they still expected within days to receive approval from a physical rehabilitation facility which had been previously contacted by Humana social worker Nancy Fred. On July 20, 1992, Fred "predicted" in her progress notes that approval by that facility, New Medco Rehabilitation Center, would take only another one to two weeks. (J.A. at 19; *id.* at 25). New Medco's expected acceptance of Johnson must have been encouraging to Fred since it was her opinion that a rehabilitation facility was more appropriate to treat Johnson's condition than was a nursing home. (*Id.* at 53).

Another significant complication in locating a facility which would accept Johnson was her inability to pay. (*Id.* at 16-18). By mid-July, 1992, Johnson's application for Kentucky Medicaid benefits had still not been approved. Johnson had no private health insurance and obviously did not have the resources to compensate any facility for her care. (Roberts Depo., R. 51 at 29; J.A. at 38-39; Fred Depo., R. 10 at 55). Johnson's medical expenses at Humana had already approached $400,000.00 and it was obvious to Humana that Johnson would never be able to

compensate it for those charges. (Deposition of John Nord, hereinafter "Nord Depo., R. 47" at 18-23). However, regardless of Johnson's inability to pay, Humana was obligated to provide treatment to her as part of a contractual relationship between Humana, the Commonwealth of Kentucky, the City of Louisville, Kentucky and Jefferson County, Kentucky whereby Humana received millions of dollars in subsidies in exchange for its agreement to provide services at no charge to Kentucky patients who did not qualify for Medicaid, who had no other resources and who were without private health insurance. (*Id.*).

In the midst of Humana's placement dilemma and shortly after Chandler had denied acceptance of Johnson, Joanna Nolte, a marketer for Hometown Living Centers ("Hometown") in Indianapolis, Indiana, visited Louisville in an effort to initiate a relationship with the Humana hospitals whereby Humana would place its patients in Hometown's Indianapolis nursing homes. (J.A. at 26-27, 41-42; Fred Depo., R. 10 at 31; Deposition of Joanna Nolte, hereinafter "Nolte Depo., R. 18" at 22).

On the evening of July 22, 1992, Nolte met with members of Humana's Social Services Department. (*Id.*). Among those who attended Nolte's presentation was Nancy Fred, who had taken charge of Johnson's discharge plan. (*Id.*). Nolte was neither a doctor nor a nurse. (Nolte Depo., R. 18 at 4). Her job was to locate potential residents for her employer's nursing homes and to refer those potential residents to administrators and directors of nursing at the respective facilities. (*Id.* at 16-17). Nolte explained that Hometown operated several nursing

homes in Indianapolis, including Mayfair Manor ("Mayfair") and Crestview Nursing Home ("Crestview"). (J.A. at 27-28; Fred Depo., R. 10 at 32). At the conclusion of Nolte's presentation, she was approached by Nancy Fred who requested that Nolte look at Johnson and consider accepting Johnson in one of the Hometown facilities. (J.A. at 42-43; Nolte Depo., R. 18 at 23-24). According to Nolte, Fred appeared to be in a real placement dilemma with Johnson. (J.A. at 48; *id.* at 31). Nolte testified that Fred complained that she was receiving pressure from the administration at Humana to find a placement for Johnson because of Johnson's inability to pay for her care. (J.A. 44-46; *id.* at 26-27). Nolte explained to Fred that Johnson's level of acuity exceeded her own unilateral authority to grant approval. However, Nolte agreed to refer Fred's request to the Administrator and Director of Nursing at Mayfair for evaluation. (J.A. 46-47; *id.* at 29-30).

All the while, Johnson's medical condition continued to be volatile. On July 23, 1992, her temperature rose to 101 degrees. (J.A. at 126-128; Abou-Jaoude Depo., R. 67 at 49-51; Exhibit "A"). A sputum culture was abnormal and her doctor suspected that she had yet another episode of urinary tract infection. (*Id.*). On the evening before her discharge, Johnson's right lung collapsed and treatment was- required every two hours. (Deposition of Donna Kaelin, R. 48 at 16). The morning of Johnson's discharge, her white blood count was over twice the normal level, her temperature had been rising for two days, and the nurses noticed cloudy urine, thick yellow sputum and an elevated heart rate, all indicating the presence of infection. (Deposition of Karen Martin, hereinafter "Martin

Depo., R. 9" at 14-19; Deposition of Suzanne Griffith, R. 49 at 9-10). The nurse on duty during Johnson's last day at Humana felt strongly enough about Johnson's condition to specifically document in her nursing notes that she had called the elevated white blood count and temprature as well as the cloudy urine to the attention of the attending physician. (Martin Depo., R. 9 at 21-23).

Meanwhile, Mayfair declined to accept Johnson because her care would require too many skilled nursing hours. (J.A. at 50; Nolte Depo., R. 18 at 33-34). However, on that same day Crestview, which had fewer skilled nurses than Mayfair, agreed to accept her. (*Id.*). The on-duty nurse at Humana learned at about midday on July 24, 1992 that Johnson would be transferred to Crestview. (Martin Depo., R. 9 at 7). In fact, the first notation that Crestview had even been considered by the social workers at Humana appeared in a social services note on July 24, 1992, wherein Nancy Fred indicated that Johnson would be transferred to Crestview on that date at 2:30 p.m. (Patient Progress Notes dated July 24, 1992 attached to Fred Depo., R. 10 at Exhibit "L").

In its haste to expedite Johnson's transfer to Crestview, Humana ignored its standard procedures and protocols for discharge and transfer. (J.A. at 11-18, 33-34; Fred Depo., R. 10 at 41-42; Policy Procedure 768-901 and 768-912). No authorization for the transfer was obtained from either Johnson's husband or mother. (*Id.*). Furthermore, although Johnson's condition had clearly deteriorated during the previous two days and Johnson wasn't even competent to understand or participate in her own discharge plan, Humana's social workers made no effort

to obtain court intervention and have a guardian or surrogate decision maker appointed for Johnson.[2] (J.A. at 22, 116; Fred Depo., R. 10 at 27-28; Abou-Jaoude Depo., R. 67 at 15). Instead, Humana unilaterally decided to ship Johnson to Indianapolis and Nancy Fred simply called Jane Roberts, Johnson's aunt and occasional visitor, ***told her*** that Johnson was being transferred to Crestview Nursing Home that afternoon and provided Roberts Crestview's telephone number. (Roberts Depo., R. 51 at 22-23, 42-43). Fred did not ask Roberts to check with Johnson's family to determine whether they would like to visit the facility before the transfer was arranged or whether they would even approve of a transfer which would place Johnson in a different state and some three hours driving distance from their home. (J.A. at 33-36; Fred Depo., R. 10 at 41-43). Fred gave Roberts no information about Crestview or about any benefits it could provide to Johnson. (Roberts Depo., R. 51 at 23-24). In fact, neither Fred nor anyone else at Humana could then provide any such information because they knew almost nothing about Crestview. (J.A. at 27-29; Fred Depo., R. 10 at 32-33, 48-49).

Fred didn't know and had failed to ask Nolte if Crestview had ever handled a patient with Johnson's level of acuity. (*Id.*). Fred also didn't know and again failed to ask whether or not Crestview had ever been

---

[2] Any interested person or entity is permitted by Ky. Rev. Stat. § 387.530 to file a petition for determination of disability and appointment of a guardian in Kentucky's District Courts. The courts are permitted to take emergency action where necessary by Ky. Rev. Stat. § 387.740.

cited for deficiencies in the care of residents. (*Id.* at 40). Despite the fact that Humana had never previously placed a patient at Crestview and despite the fact that it made no inquiries to gather even basic information, it decided to ship Johnson to Crestview and thereby rid itself of a patient who placed a serious financial drain on the hospital.

Even more significant than Humana's violation of its own discharge policy mandating that social workers advise patients or family of discharge plans in order to provide them at least an opportunity to decline the discharge and explore other arrangements, was Humana's violation of its discharge policy by failing to gain approval for the transfer from the accepting physician at Crestview. (Roberts Depo., R. 51 at 43; Abou-Jaoude Depo., R. 67 at 35-36; J.A. 6-10; Policy Procedure 0420). Crestview's doctors were unaware of Johnson's impending transfer and in fact knew nothing at all about her and her medical condition until she had already arrived. (J.A. at 80-81; Deposition of Kambiz T. Karimi, M.D., hereinafter "Karimi Depo., R. 89" at 12; Deposition of Taiseer Shatara, M.D., hereinafter "Shatara Depo., R. 90" at 10-12).

No reasonable person could argue that Crestview was an appropriate placement for Johnson. Even Crestview's own physicians admit that Crestview was inappropriate and indicated that had they known all the relevant information about Johnson's condition they would not have accepted her at Crestview. (J.A. at 81-82; Karimi Depo., R. 89 at 13; J.A. at 88-91; Shatara Depo., R. 90 at 23-26).

Johnson's condition deteriorated significantly as a result of her transfer from Humana. Upon Johnson's arrival, the nurses at Crestview were alarmed by Johnson's condition and they believed she was going to die. (J.A. at 58-59; Deposition of Charna Y. Treser, hereinafter "Treser Depo., R. 92" at 66-67). Within hours, Johnson's temperature spiked to 105 degrees and she was rushed to nearby Midwest Medical Center where she remained hospitalized for almost six months. (J.A. at 62; Deposition of John W. Stuy, M.D., hereinafter "Stuy Depo., R. 88" at 7, 71). Dr. John W. Stuy, Johnson's principal treating physician during her hospitalization in Indianapolis, testified that the complications experienced by Johnson in Indianapolis predated her transfer and were exacerbated because of her transfer to a facility which was unable to properly care for her. (J.A. at 62-69, 76-79; *id.* at 7-14, 15-17, 27-31). Humana had transferred Johnson before it had received the full lab reports relative to the infection suffered by her during the last day of her hospitalization in Louisville and simply had prescribed a broad spectrum antibiotic hoping it would fight off the infection. (P.A. at A13; J.A. at 128; Abou-Jaoude Depo., R. 67 at 51). According to Dr. Stuy, the antibiotic prescribed for Johnson when she left Humana was not sensitive to the lab cultures grown at Midwest Medical Center, indicating that the antibiotic was not treating her infection. (J.A. at 62-69, 76-79; Stuy Depo. at 7-14, 15-17, 27-31). His opinion was that if she had remained on the wrong antibiotic much longer, she may well have died. (*Id.*). Dr. Stuy emphatically stated that Johnson should never have been transferred from Humana. (*Id.*).

In addition to imperiling Johnson's life and health, Humana's hurried transfer of Johnson to Indianapolis placed her in fiscal peril because she was ineligible for public medical assistance in Indiana. (Stipulations dated April 20, 1995, R. 62). Had she remained hospitalized at Humana, Johnson would not have incurred personal liability for the payment of hundreds upon hundreds of thousands of dollars in medical expenses because of Humana's contract with Kentucky governmental entities which paid it millions of dollars annually to provide care to indigent patients. (Nord Depo., R. 47 at 18-23). Unfortunately for Johnson, once she was transferred from Humana to Indianapolis she was no longer entitled to free medical care. Adding insult to injury, Johnson's application for Medicaid benefits in Indiana was denied because she was not a resident of Indiana. (Stipulation dated April 20, 1995, R. 62). As a direct result of Humana's unilateral decision to ship Johnson to Indiana, Johnson incurred and is now personally obligated to pay medical expenses in excess of $388,000.00. (*Id.*).

In October, 1992, Roberts was appointed as Johnson's Guardian and shortly thereafter Roberts initiated this action against Humana alleging that Humana had violated the provisions of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, *et seq.* (hereinafter "EMTALA") by transferring Johnson to Crestview before stabilizing her condition. After voluminous discovery, Humana moved the District Court for Summary Judgment on the EMTALA claim. (R. 63). In response to Humana's Motion for Summary Judgment, the District Court determined that the relevant issues were, "whether Johnson was stabilized when she was transferred to

Crestview and whether the Hospital acted with an improper motive." (P.A. at A29; Memorandum Opinion entered November 13, 1995, R. 73 at 3). The District Court concluded that genuine issues of material fact existed as to both of those issues and overruled Humana's Motion for Summary Judgment. (P.A. at A46-A47; Order entered November 13, 1995, R. 74).

However, Humana subsequently moved the District Court to reconsider that Opinion, arguing that EMTALA required Johnson to prove that the decision of the surgical resident who discharged Johnson was also "improperly motivated." (R. 78). The District Court agreed, citing affidavits of Humana doctors stating that they believed Johnson was stable when she was transferred and that Johnson's financial condition had no effect on their decision to transfer her. (J.A. at 131-137). The District Court held that Johnson's failure to produce any significant evidence in opposition to the affidavits of the Humana doctors meant she had failed to meet her burden to establish a genuine issue of material fact with respect to whether her transfer was "caused" by an improper motive. (P.A. at A50-A51; Memorandum Opinion entered February 15, 1996, R. 83).

On appeal, Johnson pointed out to the Court of Appeals for the Sixth Circuit that every other circuit court of appeals in the country which had considered the issue had expressly rejected the notion that proof of improper motive was required to establish a claim under EMTALA. However, in a 2 to 1 decision, the court chose to stand alone, holding that EMTALA required proof of improper motive to establish a claim. Straying even further from the unanimous holdings by the other circuits, it also held

that even proof of improper motive by hospital administration is insufficient to maintain an EMTALA claim and required proof that the discharging physician himself was also improperly motivated. (P.A. at A1-A25).

Johnson filed her Petition for Writ of Certiorari to this Court on July 8, 1997 and the Order of the United States Supreme Court granting certiorari on the question of whether improper motive is a required element of proof under EMTALA was entered on June 8, 1998.

SUMMARY OF ARGUMENT

A. Although EMTALA was enacted in response to the widespread perception that hospitals were "dumping" indigent or uninsured patients for purely economic reasons, the statute as ultimately passed by Congress provides protections to "any individual" who comes to an emergency department or hospital seeking emergency medical treatment and is denied needed care. 42 U.S.C. § 1395dd(a), (b)(1). This expansive language has been unanimously recognized by the Circuit Courts of Appeal, including the Sixth Circuit. However, the Sixth Circuit has substantially limited EMTALA's practical application by requiring not only proof of violation of the statute but also further proof that the cause of the statutory violation was an improper motive by the hospital.

The Sixth Circuit's injection of an improper motive requirement is not based upon any express language in EMTALA. In fact, the plain reading of EMTALA compels a conclusion clearly contrary to that reached by the Sixth Circuit but in accord with the holdings of every other

circuit court of appeals in the country which has considered the issue. EMTALA contains no motive requirement. The clear Congressional purpose of EMTALA was to deter patient dumping and to compensate victims of dumping. An interpretation of EMTALA which places the significant burden upon claimants to establish improper motive would undermine EMTALA's purpose.

Furthermore, Johnson's interpretation of EMTALA that no proof of improper motive is required is buttressed by the absence of a fault requirement in the civil enforcement subsection of Section 1395dd(d). While a neighboring subparagraph requires the Secretary of Health and Human Services to prove that hospitals and doctors have negligently violated EMTALA before civil monetary penalties can be imposed, no such fault requirement is contained in the subparagraph permitting civil enforcement of EMTALA by harmed individuals. This conspicuous absence of a fault requirement in the private cause of action subsection of EMTALA demonstrates that Congress did not intend to saddle an individual with having to prove fault in order to recover under EMTALA. The Secretary of Health and Human Services, who administers the civil monetary fine program created by EMTALA, also interprets EMTALA as containing no requirement that a claimant prove some "impermissible motive" on the part of the hospital. In short, there is no statutory basis for imposing a requirement on claimants under EMTALA to prove that a hospital's violation of the statute was the result of some improper motive, and imposing such a burden would thwart the attainment of the Act's goals.

B. The Sixth Circuit stands alone in its injection of a requirement that a claimant under EMTALA prove that the offending hospital acted with an improper motive. The Fifth Circuit expressly rejected the argument that proof of an improper motive was required under EMTALA in *Burditt v. U.S. Dept. Of Health and Human Services*, 934 F.2d 1362 (5th Cir. 1991). *Burditt*, like the case at bar, involved an EMTALA claim under Section 1395dd(b) that a patient was improperly transferred from a hospital before the patient's condition had been stabilized.

Three other Circuits have rejected the notion that a claimant is required to prove an improper motive on the part of the hospital in cases dealing with the "appropriate medical screening examination" section of EMTALA. The District of Columbia Circuit, the Fourth Circuit and the First Circuit have specifically considered the Sixth Circuit's reasoning and expressly rejected it, holding that proof of an improper motive is not required under EMTALA. Additionally, while not specifically citing the Sixth Circuit's position or addressing a claim that improper motive must be shown, four other circuits have reached conclusions that are inconsistent with the Sixth Circuit's construction of EMTALA. These courts have recognized that it is impermissible to unilaterally change the plain reading of EMTALA to impose proof requirements which have no statutory basis.

ARGUMENT

Proof Of Improper Motive On The Part Of The Hospital Is Not A Prerequisite For Recovery In A Claim Under The Emergency Medical Treatment And Active Labor Act, 42 U.S.C. § 1395dd.

This case raises a fundamental question of federal law regarding the character of proof necessary to establish a claim under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (hereinafter "EMTALA"). This Court is urged to construe the statute as plainly written, adopting the reasoning of every circuit court except the Sixth which has considered the issue and determined that EMTALA does not require proof of an improper motive on the part of the hospital as a prerequisite for recovery.

A. The Plain Reading of the Statute Compels the Conclusion That Improper Motive is Not a Required Element of an EMTALA Transfer Violation Claim.

In 1986, Congress passed EMTALA with bipartisan support and President Ronald Reagan signed the legislation into law. The Act, also referred to as the "anti-dumping" provisions of the Social Security Act, was enacted in response to the widespread perception that hospitals were "dumping"[3] indigent or uninsured patients by either denying them emergency care or transferring them to other institutions for purely economic

[3] For a thorough review of the patient dumping problem see Trieger, Note, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U.L. Rev. 1187 (1986).

reasons.[4] *See, e.g., Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994), *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 269 (6th Cir. 1990). However, patient dumping is not limited to a refusal to provide emergency room treatment. As recognized by the Supreme Court of Virginia:

> It occurs, and is equally reprehensible, at any time a hospital determines that a patient's condition may result in substantial medical costs and the hospital transfers the patient because it fears it will not be paid for those expenses.

Smith v. Richmond Memorial Hospital, 243 Va. 445, 452, 416 S.E.2d 689, 692 (1992).

Although the evolution of the statute was fueled by Congress's desire to prohibit hospitals from dumping indigent or uninsured patients, the statute as ultimately passed by Congress provides protections to far more patients. Rather than limiting the protections provided by EMTALA to indigent or uninsured individuals, application of the statutory protections against patient dumping is extended to, "any individual (whether or not eligible

---

[4] Scholars agree that the fundamental change which has occurred in institutional health care in this country is somewhat responsible for the patient dumping problem. "Hospitals were originally built primarily to care for the poor. As hospitals began treating more paying patients, new hospitals were established as business enterprises in the late nineteenth century. In the twentieth century, hospitals have become as competitive as any commercial enterprise." Paul Starr, *The Social Transformation of American Medicine*, 145-148 (1982).

for benefits under [Medicare])" who comes to an emergency department or hospital. 42 U.S.C. § 1395dd(a), (b)(1).

The federal circuit courts of appeals which have addressed the scope of EMTALA, including the Sixth Circuit, have been unanimous in recognizing the expansive language of EMTALA and have rightly extended its application to all emergency patients rather than limiting the Act's protections only to indigent patients.[5] EMTALA provides these individuals with three distinct protections. First, a hospital must provide for an "appropriate medical screening examination within the capability of the hospital's emergency department" to any individual who comes to the emergency department if a request is made on the individual's behalf for examination or treatment for a medical condition. 42 U.S.C. § 1395dd(a). Second, if

---

[5] See *Brooks v. Maryland General Hosp., Inc.*, 996 F.2d 708, 711 (4th Cir. 1993) ("the language of the Act does not require a showing that a claimant is uninsured or indigent, nor does it provide that the hospital breaches the Act's duties only when it acts with economic motives"); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990) ("we hold Congress to its words, that this statute applies to any and all patients"); *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991) ("we hold that the Act applies to any and all patients, not just patients with insufficient resources"); *Collins v. DePaul Hospital*, 963 F.2d 303, 308 (10th Cir. 1992) ("the fact that Congress . . . viewed [EMTALA] as a so-called 'anti-dumping' bill . . . does not subtract from its use of the broad term 'any individual' "); *Gatewood v. Washington Health Care Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991) ("though the . . . Act's legislative history reflects an unmistakable concern with the treatment of uninsured patients, the Act itself draws no distinction between persons with and without insurance").

a medical screening examination reveals that an "emergency medical condition"[6] exists, the hospital must then provide the patient with treatment necessary to "stabilize"[7] this condition. 42 U.S.C. § 1395dd(b)(1). Finally, the hospital is prohibited from effecting a "transfer"[8] of the

---

[6] 42 U.S.C. § 1395dd(e)(1) provides that the term "emergency medical condition" means –

> "(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant women [woman] who is having contractions –
>
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
>
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."

[7] 42 U.S.C. § 1395dd(e)(3)(A) provides that the term "to stabilize" means, "with respect to an emergency medical condition described in paragraph (1) (A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1) (B), to deliver (including the placenta)."

[8] 42 U.S.C. § 1395dd(e)(4) provides that the term "transfer" means "the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person."

individual from the hospital if the emergency medical condition has not been "stabilized"[9] unless rigid statutory requirements are met by the hospital.[10]

EMTALA, as passed by Congress, does not contain an express requirement that an improper or non-medical motive be proven to establish a claim for violation and no such requirement can reasonably be implied from the language of the statute. Nor does Humana base its argument on the Act's express language. Further, no court of appeals, other than the Sixth Circuit, has imposed such a requirement on any litigant. The Sixth Circuit has substantially limited EMTALA's practical application by inventing a proof requirement found nowhere in the statute. The Sixth Circuit has determined that in addition to

---

[9] 42 U.S.C. § 1395dd(e)(3)(B) provides that the term "stabilized" means, "with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)."

[10] Humana does not contend that the "appropriate transfer" provisions of 42 U.S.C. § 1395dd(c)(2) apply in this case.

showing a violation of the statute, an improper, or non-medical, motive must also be proven as an element of EMTALA for both inappropriate screening and transfer claims. *Roberts v. Galen of Virginia, Inc.*, 111 F.3d 405 (6th Cir. 1997); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990).

The "improper or non-medical motive" requirement was first espoused by the Sixth Circuit in *Cleland*. *Cleland* involved an allegedly inappropriate screening examination under Section 1395dd(a). In that case, the Clelands took their fifteen year old son to the hospital emergency room complaining of cramps and vomiting. During the medical screening examination, the child's condition was misdiagnosed as influenza and the child was sent home. Less than twenty-four hours later, the child suffered cardiac arrest and died.

In analyzing EMTALA, the Sixth Circuit determined that Congress had limited "the cause of action provided by the Act to only those who did not receive an 'appropriate' screening or who were not 'stabilized' before being transferred or discharged." *Cleland*, 917 F.2d at 271. The court determined that the term "appropriate" used by Congress in describing the required medical screening examination of Section 1395dd(a) was ambiguous. It purportedly looked to legislative history, along with other aids to construction, and determined that in the context of EMTALA, " 'appropriate' must . . . correctly be interpreted to refer to the motives with which the hospital acts. If it acts in the same manner as it would have for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute." *Id.* at 272.

Extending its statutory misinterpretation to the next illogical step, the Sixth Circuit in *Cleland* as well as in the case at bar reasoned that the same improper or non-medical motive requirement that it had extrapolated from its construction of the adjective "appropriate" in the medical screening requirement of 42 U.S.C. § 1395dd(a) also applied to the Section 1395dd(b) prohibition against transferring unstabilized patients, "though with even greater force." *Id.* at 271. However, the Sixth Circuit's analysis fails as a textual matter because the term "appropriate" contained in the medical screening requirement of the statute, and upon which the Sixth Circuit based its entire analysis, is found nowhere in the section of the statute which requires necessary stabilizing treatment.[11] Rather than taking notice of the absence of the key word "appropriate," the Sixth Circuit's analysis proceeds as if the Congressional omission has no significance. In fact, the Sixth Circuit did not even purport to rely upon any

---

[11] The Sixth Circuit's exercise in statutory misinterpretation did not stop there. It next ignored the fact that the statute imposes direct rather than vicarious liability on Humana and determined that Johnson's showing of an improper non-medical motive on the part of hospital administration and social services staff was *not* sufficient if the independent contractor surgical resident who signed Johnson's discharge was not also implicated in the improper conduct. It is clear that, even if improper motive is a required element of proof under EMTALA, Johnson has established sufficient evidence of improper motive on the part of Humana employees or administration to withstand Summary Judgment. Therefore, even if this Court determines that proof of an improper motive is required, it should nevertheless reverse the decision of the Sixth Circuit in this case with directions to remand the case to the District Court for trial.

express language in § 1395dd(b) that could be construed to impose an improper motive requirement for failure to stabilize and improper transfer claims.

A proper reading of the statute considers the stabilization requirement in its entire context and compels a conclusion clearly contrary to that reached by the Sixth Circuit and consistent with the holdings of the other circuits. The plain terms of the statute require proof only of a violation, causation and damages. EMTALA contains no motive requirement. The statute requires only that Johnson show that she was transferred from Humana's hospital and that her emergency medical condition had not been stabilized at the time of transfer.

The evidence adduced thus far certainly is sufficient to allow a trier of fact to conclude that a statutory violation occurred. Johnson was transferred while she had an active infection and just hours after her lung had collapsed. Rather than waiting a few additional hours for full lab reports to be completed so that an appropriate medication could be prescribed, Humana did little more than pull an antibiotic out of the medicine cabinet and hope it would work. Humana's effort to rid itself of Johnson almost cost Johnson her life and certainly caused material deterioration in her condition. For this reason, the District Court determined that Johnson was entitled to a jury trial on the issue of whether she was stable when transferred if improper motive was not a required additional element of proof. That finding was not challenged by Humana on appeal. (P.A. at A3-A4, A13-A14).

Johnson's assertion that recovery under the transfer and stabilization provisions of EMTALA is not predicated

on motive is consistent with the Congressional purpose of EMTALA to deter patient dumping and to compensate victims of dumping. The purpose of EMTALA was "to send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." 131 Cong. Rec. S. 13,904 (Daily Ed. Oct. 23, 1985) (Statement of Senator Durenberger).

This interpretation is buttressed by the absence of a fault requirement in the civil enforcement subsection of Section 1395dd(d). Subparagraph (1) provides for civil monetary penalties imposed by the Secretary of Health and Human Services ("Secretary") against hospitals and doctors who ***negligently*** violate EMTALA. Subparagraph (2) of § 1395dd(d) allows civil enforcement of EMTALA to any "individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section. . . . "

Conspicuously absent from the civil enforcement provisions of the statute is any requirement that a harmed individual prove that a hospital's violation was intentional, knowing, or even negligent. The omission of a fault requirement in the private right of action provision when its neighboring subsection contains such a requirement is a clear indication that the omission was intentional and suggests that a harmed individual can prevail on a lesser showing than would be required of the Secretary in imposing a civil penalty. "It is generally presumed that Congress acts intentionally and purposely" when it "includes particular language in one section of a statute but omits it in another." *City of Chicago*

v. Environmental Defense Fund, 511 U.S. 328, 338 (1994) (citing *Keene Corp. v. United States*, 508 U.S. 200, 208 (1993)). Clearly, the express requirement of negligent conduct for civil penalties and the lack of such an express requirement for civil enforcement does not support a conclusion that a private plaintiff must make the greater showing of improper motive required by the Sixth Circuit in this case.

The Secretary of Health and Humana Services has also concluded that proof of improper motive is not an essential element of an EMTALA violation claim. In the preamble to Interim Final Rules and Regulations governing the Department's Health Care Financing Administration and its Office of the Inspector General, the Secretary stated: "Also with regard to appropriate transfers, we note that the Secretary has taken the position that in proving that a hospital or physician violated [42 U.S.C. § 1395dd(b)], there is no requirement to prove that the transfer was effected due to some 'impermissible motive.' " 59 Fed. Reg. 32,086, 32,104 (1994). HHS administers the civil monetary fine program created by EMTALA. *See* 42 U.S.C. § 1395dd(d)(3). Accordingly, because HHS's interpretation is reasonable, it deserves deference. *See Martin v. OSHRC*, 499 U.S. 144 (1991); *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-845 (1984).

The total absence of any requirement in EMTALA that motive be proven demonstrates Congress' intent to spare patients the burden of proving they were denied treatment because of intentional discrimination based on some improper or non-medical motive. In contrast, statutes like Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e *et seq.*, which prohibits discrimination in

employment "*because of*" an "individual's race, color, religion, sex, or national origin," *id.* at § 2000e-2(a)(1) (emphasis added), make clear that Congress knows how to write an intent or effects-based law when it is so inclined.

Furthermore, Congress' decision to make motive irrelevant is entirely logical. As this Court well knows from Title VII cases, motive and intent are always difficult to prove. *See Texas Dept. of Community Affairs v. Burdine*, 450 U.S. 248 (1981); *McDonnell-Douglas v. Green*, 411 U.S. 792, 805 (1973). Those standards often create vexing proof problems, as evidence of discriminatory intent is rarely set forth in documents or other records. Congress understood that hospitals and physicians involved in dumping would have no trouble advancing plausible-sounding medical explanations for their conduct which, in fact, would be pretexts to disguise violations of EMTALA nor would they leave a paper trail of documents evidencing their improper motive. Congress clearly intended not to saddle patients, physicians, hospitals and the courts with the time-consuming, expensive, fact-intensive battles that are inevitable whenever a *Burdine*-type inquiry is required. There is no reason to believe that Congress intended to add to patients' burden by requiring them to prove improper motives as well as violations of EMTALA, particularly where Congress' sole concern was to ensure access to appropriate emergency medical treatment for all.

B. Proof of an Improper Motive to Establish a Claim Under EMTALA Has Been Expressly or Implicitly Rejected By Every Other Circuit Court of Appeals Which Has Considered the Issue.

The Sixth Circuit stands alone in its injection of a requirement that a claimant under EMTALA prove that the offending hospital acted with an improper motive. As a result, claimants in the Sixth Circuit must prove more than their counterparts anywhere else in the country. The statute has thus been so narrowed that it may be virtually impossible for an EMTALA claimant to prevail in the Sixth Circuit. Recognizing that the court cannot impose an element necessary for a cause of action under EMTALA where the statute makes no such provision, the other circuit courts of appeals have rejected improper or non-medical motive as a requirement of proof under EMTALA.

The Fifth Circuit Court of Appeals expressly rejected the argument that proof of an improper motive was required under EMTALA in *Burditt v. U.S. Dept. of Health & Human Serv's*, 934 F.2d 1362 (5th Cir. 1991). *Burditt*, like the case at bar, involved an EMTALA claim under § 1395dd(b) that a patient was improperly transferred from a hospital before the patient's condition had been stabilized. In that case, a physician transferred a patient in active labor to another hospital without insuring that the patient's condition was "stabilized." The Secretary imposed a civil penalty against the physician. The Fifth Circuit affirmed the civil penalty in spite of the physician's argument that the Secretary was required to prove

that he had acted with an improper motive. In rejecting this assertion, the Fifth Circuit stated as follows:

> Burditt asks this court to invent a requirement found nowhere in the statute that an improper, or non-medical, motive for transfer must be proved as an element of all EMTALA transfer violations. As written, EMTALA prevents patient dumping without such a requirement. . . . We refuse to alter the statutory scheme.

Burditt, 934 F.2d at 1373 (internal citation omitted).

Other circuits have rejected the notion that a claimant is required to prove an improper motive on the part of the hospital in cases dealing with the "appropriate medical screening examination" section of EMTALA. In *Gatewood v. Washington Health Care Corp.*, 933 F.2d 1037 (D.C. Cir. 1991), the District of Columbia Circuit became the first appellate court to expressly reject the Sixth Circuit's reasoning in *Cleland*. In that case, Mrs. Gatewood's husband died after he was discharged from the Defendant hospital's emergency room. She brought an action under EMTALA claiming that the hospital misdiagnosed her husband's condition in its emergency room. The trial court granted the hospital summary judgment noting that Mrs. Gatewood's allegations of misdiagnosis, without more, were simply not actionable under EMTALA.

In specifically rejecting the Sixth Circuit's reasoning in *Cleland* and in specifically holding that improper motive is not a prerequisite to recovery under even the medical screening portion of the statute, the D.C. Circuit stated as follows:

> In our view, the hospital fulfills the "appropriate medical screening" requirement when it conforms in its treatment of a particular patient to its standard screening procedures. By the same token, any departure from standard screening procedures constitutes inappropriate screening in violation of the Emergency Act. The motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided others and guaranteed him or her by subsection 1395dd(a).

Gatewood, 933 F.2d at 1041.

The reasoning of the District of Columbia Circuit was followed, and that of the Sixth Circuit again repudiated, by the Fourth Circuit in *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994). In that case Mrs. Power came to the Arlington Hospital emergency room complaining of pain in her hip, her lower abdomen, and in her back running down her leg, and reporting that she was unable to walk, was shaking and had severe chills. After being discharged with directions to take pain medication and call an orthopedist if the pain got worse, Power returned to the emergency room the next day and was diagnosed as suffering from septic shock and was immediately admitted to the intensive care unit of the hospital where she remained for over four months.

Mrs. Power brought an action against Arlington Hospital claiming that she had not received an appropriate medical screening examination on her first visit to the hospital and upon subsequent admission that she was transferred before her condition had been stabilized. She did not contend, and was unable to offer proof, that the

hospital's failure to provide an appropriate medical screening examination or that her transfer before stabilization had been based on any improper motive. The case was tried before a jury and a multi-million dollar verdict was rendered in favor of Mrs. Power on the medical screening count of her complaint but in favor of the hospital on her claim that she had been transferred in an unstable condition. On appeal of the verdict, the Fourth Circuit rejected the hospital's argument that Power was required to prove improper motive to succeed on her EMTALA claim, explaining as follows:

> First, there is nothing in the statute itself that requires proof of indigence, inability to pay or any other improper motive on the part of a hospital as a prerequisite to recovery. The language of subsection 1395dd(a) simply refers to "any individual" who presents to the emergency room. Second, it seems to us that the expanse of motives suggested by the Sixth Circuit in *Cleland* is so broad as to be no limit at all, and as a practical matter amounts to not having a motive requirement. Anyone who alleges that she did not receive an appropriate medical screening examination can simply find an improper motive that fits, whether it is sex, nationality, income or occupation, and simply allege it. Which leads, thirdly, to the most fundamental problem with the motive requirement: the proof predicament. We agree with Power's position that having to prove the existence of an improper motive on the part of a hospital, its employees or its physicians, would make a civil EMTALA claim virtually impossible. We do not believe that proving the inner thoughts and

> prejudices of attending hospital personnel is required in order to recover under EMTALA.

Power, 42 F.3d at 857-858.

The First Circuit, too, has rejected the *Cleland* position and followed the District of Columbia and Fourth Circuits. *Correa v. Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996). In *Correa*, Mrs. Gonzales appeared at the emergency room of Hospital San Francisco presenting chest pains. She was given a number and was asked to wait. After waiting for what was apparently several hours without treatment, Mrs. Gonzales left the hospital without being evaluated and apparently upon referral from the hospital went to a doctor's office. Shortly after arriving at the doctor's office, she collapsed and died. Her family sued the hospital claiming that it had not provided an appropriate medical screening to Mrs. Gonzales when she appeared at the hospital emergency room. Mrs. Gonzales's family did not, and in fact they could not, offer proof that the hospital acted with an improper motive. The First Circuit concurred with the reasoning of both *Power* and *Gatewood* and held that EMTALA does not impose a motive requirement. It noted that *Cleland*,

> required there to be *some* motive-whether or not economic-for the disparate treatment. . . . Other courts have declined to follow the Sixth Circuit's lead in this respect, . . . and we agree that the range of improper motives available under the *Cleland* standard "is so broad as to be no limit at all, and as a practical matter amounts to not having a motive requirement."

Id. at 1194 n.9.

While not specifically citing the Sixth Circuit's position or addressing a claim that improper motive must be shown, four other circuits have considered "appropriate medical screening" cases and have reached conclusions that are inconsistent with the Sixth Circuit's construction of EMTALA. The conclusion of those courts has been that the appropriateness of a medical screening examination under EMTALA depends not on the motivation with which the hospital acted in failing to follow standard screening procedures but, instead, on whether the screening examination is even-handedly administered to all patients whose medical conditions are in relevant respects similar. *See Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("[T]he test is whether the challenged procedure was identical to that provided similarly situated patients."); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994) ("[A] hospital satisfies the requirements of § 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances."); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) ("As long as a hospital applies the same screening procedures to indigent patients which it applies to paying patients, the hospital does not violate [Section 1395dd(a)]."); *See also Marshall v. East Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998) ("[A]n EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was

performed equitably in comparison to other patients with similar symptoms.").[12]

The universal rejection of the Sixth Circuit's creation of an improper motive requirement under EMTALA makes it abundantly clear that other courts find no such limiting language in EMTALA and recognize that they cannot unilaterally change the plain reading of the statute.

CONCLUSION

The judgment of the Court of Appeals for the Sixth Circuit should be reversed. This case should be remanded to the United States District Court for the Western District of Kentucky for a trial on the merits of Johnson's claim that Humana violated the provisions of EMTALA.

Respectfully submitted on July 23, 1998,

JOSEPH H. MATTINGLY III
Counsel of Record for the Petitioner

JOSEPH H. MATTINGLY III, P.S.C.
Attorney at Law
P.O. Box 678
104 West Main Street
Lebanon, Kentucky 40033
(502) 692-1718

[12] The question of whether these circuits are correct in using an "even-handedness" standard is not before the Court and not necessary to the decision in this case. Although it is not apparent from the plain reading of EMTALA that a claimant must prove "even-handedness," it *is* apparent that Humana departed substantially from its ordinary practice in discharging and transferring Johnson.

42 U.S.C. § 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual (whether or nor eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor. (1) In general. If any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either –

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual

(or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized. (1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless –

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1) [42 USCS § 1395x(r)(1)]) has signed a certification that [,] based upon the

information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1) [42 USCS § 1395x(r)(1)]), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(b) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer –

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility –

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement. (1) Civil monetary penalties. (A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less

than 100 beds) for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who –

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this title [42 USCS §§ 1395 et seq.] and State health care programs. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same

manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I) [42 USCS § 1395cc(a)(1)(I)]) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) **Civil enforcement. (A) Personal harm.** Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the

hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations. In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI [42 USCS §§ 1320c et seq.]) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) **Definitions.** In this section:

(1) The term "emergency medical condition" means –

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bcdily organ or part; or

(B) with respect to a pregnant women [woman] who is having contractions –

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "particpating hospital" means hospital that has entered into a provider agreement under section 1866 [42 USCS § 1395cc].

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical

probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a rural primary care hospital (as defined in section 1861(mm)(1) [42 USCS § 1395x(mm)(1)]).

(f) Preemption. The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination. A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment. A participating hospital may not delay provision of an appropriate

medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) **Whistleblower protections.** A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(Aug. 14, 1935, ch. 531, Title XVIII, Part C, § 1867, as added April 7, 1986, P. L. 99-272, Title IX, Subtitle A, Part 1, Subpart B, § 9121(b), 100 Stat. 164; Oct. 21, 1986, P. L. 99-509, Title IX, Subtitle D, Part 1, § 9307(c)(4), 100 Stat. 1996; Oct. 22, 1986, P. L. 99-514, Title XVIII, Subtitle C, Ch 1, § 1895(b)(4), 100 Stat. 2933; Dec. 22, 1987, P. L. 100-203, Title IV, Subtitle A, Part 1, § 4009(a)(1), (2), 101 Stat. 1330-56; July 1, 1988, P. L. 100-360, Title IV, Subtitle B, § 411(b)(8)(A)(i), 102 Stat. 772; Oct. 13, 1988, P. L. 100-485, Title VI, § 608(d)(18)(E), 102 Stat. 2419; Dec. 19, 1989, P. L. 101-239, Title VI, Subtitle A, Part 1, Subpart A, § 6003(g)(3)(D)(xiv), Part 3, Subpart B, § 6211(a)-(h), 103 Stat. 2154, 2245; Nov. 5, 1990, P. L. 101-508, Title IV, Subtitle A, Part 1, § 4008(b)(1)-(3)(A), Part 3, § [4207]4027(a)(1)(A), (2), (3), (k)(3), 104 Stat. 1388-44, 1388-117, 1388-124.)

Supreme Court, U.S.
FILED
SEP 22 1998
CLERK

(9)

No. 97-53

IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

JANE M. ROBERTS,
Guardian for Wanda Y. Johnson,
Petitioner,

v.

GALEN OF VIRGINIA, INC.,
d/b/a University of Louisville Hospital,
Respondent.

RECEIVED
HAND DELIVERED
SEP 22 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

---

BRIEF OF RESPONDENT

BRYAN TODD THOMPSON
THOMAS S. CALDER
MILLICENT A. TANNER
DINSMORE & SHOHL LLP
2000 Meidinger Tower
Louisville, KY 40202
(502) 585-2450

CARTER G. PHILLIPS *
JACQUELINE GERSON COOPER
SIDLEY & AUSTIN
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 736-8000

Counsel for Respondent

*Counsel of Record

September 22, 1998

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

BEST AVAILABLE COPY

54 PP

QUESTION PRESENTED

Whether a patient may recover under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, where she was appropriately screened by respondent's emergency room as having an emergency medical condition consisting of life-threatening trauma injuries, admitted to the hospital where the emergency condition was stabilized, treated for over two months, and then transferred to a skilled nursing facility for rehabilitation services while taking antibiotics for a urinary tract infection or possible pneumonia.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	v
INTRODUCTION	1
STATEMENT OF THE CASE	5
Statutory Background	5
Factual Background	6
Procedural History	13
SUMMARY OF ARGUMENT	15
ARGUMENT	18
I. EMTALA DOES NOT FUNDAMENTALLY ALTER THE CONSTITUTIONAL BALANCE BETWEEN FEDERAL AND STATE RELATIONS BY CREATING A FEDERAL STANDARD OF CARE FOR MEDICAL DIAGNOSIS AND TREATMENT FOR ALL PATIENTS WHO ENTER A HOSPITAL'S EMERGENCY ROOM	21
II. ALTHOUGH THE COURT OF APPEALS' MOTIVE TEST LACKS A CLEAR STATUTORY ANCHOR, THE COURT SHOULD CONSIDER ALTERNATIVE GROUNDS FOR AFFIRMANCE THAT WILL REINFORCE THE UNIFORM RULE IN THE COURTS OF APPEALS THAT EMTALA SHOULD BE CONSTRUED NARROWLY TO PRESERVE STATE LAW REGULATING THE QUALITY OF MEDICAL CARE IN HOSPITALS	32

TABLE OF CONTENTS—Continued

	Page
III. THE JUDGMENT BELOW SHOULD BE AFFIRMED BECAUSE RESPONDENT WAS UNDER NO DUTY TO STABILIZE MS. JOHNSON SINCE HER TREATING PHYSICIANS DID NOT HAVE ACTUAL KNOWLEDGE THAT SHE WAS SUFFERING FROM AN EMERGENCY MEDICAL CONDITION AT THE TIME THEY ORDERED HER TRANSFER	35
IV. THE JUDGMENT BELOW SHOULD BE AFFIRMED BECAUSE EMTALA DOES NOT APPLY TO TREATMENT AND DISCHARGE DECISIONS OCCURRING AFTER A PATIENT'S INITIAL SCREENING AND STABILIZING TREATMENT	41
CONCLUSION	48

TABLE OF AUTHORITIES

CASES

	Page
Atascadero State Hosp. v. *Scanlon*, 473 U.S. 234 (1989)	22
Bailey v. *United States*, 516 U.S. 137 (1995)	28
Blonder-Tongue Labs., Inc. v. *University of Illinois Found.*, 402 U.S. 313 (1971)	34
Brooks v. *Maryland Gen. Hosp., Inc.*, 996 F.2d 708 (4th Cir. 1993)	2, 44
Bryan v. *Rectors and Visitors of Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996)	1, 41, 42, 44, 45
Cipollone v. *Liggett Group, Inc.*, 505 U.S. 504 (1992)	22
Cleland v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990)	2, 14, 24, 36
Collins v. *DePaul Hosp.*, 963 F.2d 303 (10th Cir. 1992)	41, 43
Correa v. *Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995)	4, 24
Dandridge v. *Williams*, 397 U.S. 471 (1976)	34
Eberhardt v. *City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995)	1, 4, 24, 36
Edmonds v. *Compagnie Generale Transatlantique*, 443 U.S. 256 (1979)	30
Gatewood v. *Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991)	2, 4, 24, 36, 37, 44
Gregory v. *Ashcroft*, 501 U.S. 452 (1991)	22
Hillsborough County v. *Automated Med. Labs., Inc.*, 471 U.S. 707 (1985)	23
Holcomb v. *Monahan*, 30 F.3d 116 (11th Cir. 1994)	4, 25, 36
Marshall v. *East Carroll Parish Hosp.*, 134 F.3d 319 (5th Cir. 1998)	4, 24, 36
Medtronic, Inc. v. *Lohr*, 518 U.S. 470 (1996)	23
Owens v. *Bellevue Hosp. Ctr.*, No. 95-9016, 1996 WL 134227 (2d Cir. Mar. 25, 1996)	25
Platt v. *Union Pac. R.R. Co.*, 99 U.S. 48 (1878)	28
Repp v. *Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994)	4, 25
Rice v. *Santa Fe Elevator Corp.*, 331 U.S. 218 (1947)	22

TABLE OF AUTHORITIES—Continued

	Page
Silkwood v. *Kerr-McGee Corp.*, 464 U.S. 238 (1984)	23
Summers v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996)	4, 24, 36, 37
United States v. *Bass*, 404 U.S. 336 (1971)	16, 22, 30
United States v. *Nordic Village, Inc.*, 503 U.S. 30 (1992)	28
Urban by and Through Urban v. *King*, 43 F.3d 523 (10th Cir. 1994)	36, 37, 39
Vance v. *Terrazas*, 444 U.S. 252 (1980)	34
Vickers v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996)	4, 24, 36, 37, 38
Washington v. *Yakima Indian Nation*, 439 U.S. 463 (1979)	34
Will v. *Michigan Dept. of State Police*, 491 U.S. 58 (1989)	21

LEGISLATIVE HISTORY

131 Cong. Rec. 28,568 (1985)	30
131 Cong. Rec. H9503 (daily ed. Oct. 23, 1985) (statement of Rep. Bilirakis)	44
131 Cong. Rec. S13,904 (daily ed. Oct. 23, 1985) (statement of Sen. Kennedy)	5
131 Cong. Rec. S13,904 (daily ed. Oct. 23, 1985) (statement of Sen. Dole)	44
H.R. Rep. No. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 605	19, 43
H.R. Rep. No. 100-531, at 7 (1988)	5

STATUTES

42 U.S.C. § 1395dd	*passim*

IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

No. 97-53

JANE M. ROBERTS,
Guardian for Wanda Y. Johnson,
Petitioner,
v.
GALEN OF VIRGINIA, INC.,
d/b/a University of Louisville Hospital,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF RESPONDENT

INTRODUCTION

The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), has spawned an extraordinary number of federal appellate court decisions. What is particularly striking is the number of those cases in which the courts of appeals have affirmed judgments in favor of the hospital, but felt compelled to do so on the basis of a legal theory different from the one employed by a lower court.[1]

[1] *See, e.g., Bryan* v. *Rectors and Visitors of Univ. of Va.*, 95 F.3d 349, 350-51 (4th Cir. 1996); *Eberhardt* v. *City of Los Angeles*,

The reason for this unusual phenomenon is not particularly difficult to ascertain: the lower courts are struggling with the inherent tension between the language of the statute—which at best only inartfully addresses the core concern that animated Congress's passage of EMTALA, viz., to prevent the practice of patient "dumping"—and the absence of any proof that Congress meant to supersede the States' traditional plenary authority over medical malpractice. Thus, the lower courts have grasped at a variety of limiting principles, some of which have more support in the statute than others.

In this case the Sixth Circuit has accomplished what is unquestionably the correct result. It is utterly counter-intuitive to imagine that Congress meant for EMTALA to apply to a transfer occurring months after a patient's admission to a hospital simply because the patient was suffering from a urinary tract infection at the time the patient was transported to a skilled nursing facility, which was plainly competent to treat this relatively minor condition. However, the Sixth Circuit reached this result by selecting a theory that, while conceptually consistent with Congress's desire to proscribe patient transfers that are made for financial or other non-medical reasons, is not supported by the language and structure of the statute. The Sixth Circuit, following its own prior precedent, identified petitioner's failure to prove that the transfer decision was prompted by an improper motive as an element of the EMTALA cause of action. After a careful review of the language and structure of the statute, respondent cannot defend the court of appeals' rationale.

That should not, however, be the end of the Court's inquiry. This is the first case this Court has agreed to

---

62 F.3d 1253, 1257 (9th Cir. 1995); *Brooks* v. *Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 709-10 (4th Cir. 1993); *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1040-41 (D.C. Cir. 1991); *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990).

review arising under EMTALA. Moreover, the United States, in its amicus brief, has put forth a strikingly provocative argument, i.e., EMTALA creates a federal medical malpractice standard that applies in this case and petitioner's claim should be allowed to go to trial on the question whether respondent failed to comply with that federal standard of care. In sum, the United States has addressed this case with a much broader brush than petitioner and has urged the Court to adopt a sweeping interpretation of EMTALA.

Respondent urges the Court to follow the unanimous decisions of the courts of appeals that have held that EMTALA is not a federal malpractice statute. Moreover, this case remains a suitable vehicle for the Court to recognize that there are significant limitations on the scope of a hospital's duties under EMTALA. At a minimum, the Court should consider the consensus opinion of the courts of appeals that a transfer or discharge by a hospital upon physician's orders, if the physician lacks actual knowledge that the patient has an emergency medical condition, does not violate EMTALA. The lower courts unanimously hold that actual knowledge is required. In this case, it is undisputed that the medical personnel at the hospital believed that petitioner's condition was stabilized at the time she was transferred. Certainly, no physician at the hospital perceived that respondent's medical condition constituted any type of "emergency." Thus, the question whether a physician's actual knowledge is an element of the plaintiff's claim is an important one that the Court should resolve in this case, where the evidence is uncontested that the patient's treating physicians did not consider her infection to constitute a serious problem.

Alternatively, the Court should consider the holdings of the Fourth and Tenth Circuits that EMTALA does not apply to treatment and discharge decisions occurring after a patient's initial screening and stabilizing treatment.

It is clear that the Sixth Circuit could have applied precisely this rationale to this case and the judgment would be unassailable. If that interpretation of EMTALA is correct, then this Court should recognize this alternative ground for affirmance and make clear that the United States is simply wrong in urging the Court to interpret EMTALA as a sweeping federal malpractice statute that applies to every discharge or transfer decision.[2]

In sum, respondent realizes that the Court granted the petition in this case with an intention to resolve merely the issue of whether a requirement of proof of illicit motive is an element of an EMTALA claim. To be sure, the Court can set aside the judgment on that basis. If the Court goes no further, then it probably will not significantly impede the vital progress the lower courts have made in confining EMTALA to its limited purpose of

[2] By identifying two alternative grounds for affirmance in this case, respondent does not mean to suggest that they are the only possible limiting principles for EMTALA. The courts of appeals have identified several others. For example, several courts of appeals apply a "disparate treatment" test to determine whether a patient received appropriate screening under EMTALA. Under this test, a hospital violates EMTALA's screening obligation only when it fails to apply its screening procedures uniformly to all patients who are similarly situated. *See, e.g., Marshall* v. *East Carroll Parish Hosp.*, 134 F.3d 319, 322-23 (5th Cir. 1998); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996); *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143-45 (4th Cir. 1996); *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1257-58 (9th Cir. 1995); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); *Repp* v. *Anadarko Mun. Hosp.*, 43 F.3d 519, 521-22 (10th Cir. 1994); *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).

In an appropriate case, application of the "disparate treatment" test—or other limiting principles—might be appropriate. That issue was not litigated here because the parties agree that respondent provided an appropriate medical screening in this case. In contrast, the two alternative grounds proposed by respondent were raised and hence are legitimately posed here.

ensuring that all federally-funded hospitals are accessible to patients requiring emergency medical care. If, however, the Court were to entertain the United States' more aggressive interpretation of EMTALA, then respondent urges the Court to recognize that the judgment below is fully consistent with other courts of appeals' interpretations of this statute and thus there are alternative grounds available for affirmance that will permit this Court to provide important guidance to lower courts that now routinely face EMTALA claims whenever a medical malpractice action is asserted for allegedly negligent treatment arising in the hospital setting.

STATEMENT OF THE CASE

Statutory Background

Congress enacted EMTALA to prevent hospitals from "dumping patients," that is, from transferring patients upon physician's orders to other institutions for economic or other non-medical reasons. The problem of patient dumping became acute in the 1980's for two reasons. First, the number of Americans who lacked health insurance grew rapidly from the late 1970's through the mid-1980's. H.R. Rep. No. 100-531, at 7 (1988). Second, by reforming the Medicare payment system in 1983, Congress eliminated the ability of hospitals to pass on to the government the costs of caring for indigent patients. *Id.* Given these systemic incentives for hospitals not to admit indigent or uninsured patients, Congress concluded that federal legislation was necessary because "28 States [had] no" laws that would "ensure that no emergency patient is denied emergency care because of inability to pay." 131 Cong. Rec. S 13,904 (daily ed. Oct. 23, 1985) (statement of Sen. Kennedy).

The Act responds to the patient-dumping problem by requiring hospitals to provide patients for whom treatment is requested in an emergency room with (a) an appropriate medical screening examination, and with either

(b) stabilizing treatment of the emergency medical condition or (c) an appropriate transfer to another medical facility for such treatment. 42 U.S.C. §§ 1395dd(a), (b), (c). The Act provides for multiple methods of enforcement, and thus Congress did not look to private individuals as the primary enforcers of its ban on patient dumping. First, the Secretary of Health and Human Services can impose civil money penalties on participating hospitals and physicians who negligently violate any requirement of the Act. 42 U.S.C. § 1395dd(d)(1). Any physician who commits a violation that is "gross and flagrant or is repeated" also can be excluded by the Secretary from participation in Medicare and state health care programs. 42 U.S.C. § 1395dd(d)(1)(B). Second, any individual who suffers harm as a direct result of a violation by a participating hospital can bring a private civil action to recover damages for personal injury that are available under state law. 42 U.S.C. § 1395dd(d)(2)(A). Third, a medical facility, such as a transferee hospital, that suffers a financial loss as a direct result of a violation by a participating hospital also can bring a civil action to recover damages that are available under state law. 42 U.S.C. § 1395dd(d)(2)(B). The relevant provisions of EMTALA are reprinted in the appendix to the petition for certiorari. Pet. App. A55-A66.

Factual Background

Wanda Johnson was severely injured when she was struck by a motor vehicle on May 9, 1992. She was taken to the emergency room of Humana Hospital University of Louisville ("Humana"), which is a teaching hospital affiliated with the University of Louisville. Pursuant to an arrangement with the Commonwealth of Kentucky, the City of Louisville and Jefferson County, Kentucky, Humana is obligated to provide emergency and other treatment to all individuals who request it, regardless of ability to pay. This arrangement continues the

University of Louisville's historic role of ministering to the health care needs of indigent patients as a public service in the course of its teaching programs. Indeed, Humana is the primary facility in the Louisville area that provides emergency care to indigent individuals.

Humana's emergency room physicians diagnosed Ms. Johnson as having life-threatening injuries, and admitted her to the hospital. Ms. Johnson was diagnosed and treated for multiple fractures to her pelvis, right leg and four vertebrae of her spine. She also suffered a serious head injury. During surgery Ms. Johnson's spleen was removed and she was connected to a ventilator. Her condition was stabilized and she continued to be treated by the hospital for over two months, during that time she was removed from the ventilator.

By July, Ms. Johnson was "pretty much on a steady course of showing improvement." J.A. 117 (Deposition of Walid Abou-Jaoude, M.D. ("Abou-Jaoude Dep."), R. 67, at 17).[3] Indeed, she was "stable" throughout July and was moved to a "step-down unit" within the hospital (a unit that involves "less intensive" care) a couple of weeks before her discharge. *Id.* at 116-18 (Abou-Jaoude Dep. at 15, 17). Ms. Johnson suffered recurrent pneumonia and urinary tract infections during her stay at Humana as a result of being on a ventilator and having a chronic indwelling catheter, but these conditions were successfully treated with antibiotics and did not cause her health to become unstable. Abou-Jaoude Dep. at 14-15, 17-18.

When Ms. Johnson's doctors—who are independent contractors and not employees of Humana—made the medical determination that she was "stable enough to be transferred" and "making progress," they instructed the

---

[3] The Joint Appendix is cited as "J.A. ——." The Appendix to the Petition for Certiorari is cited as "Pet. App. ——." Deposition transcripts and other record materials are identified by their docket number in the record.

social workers and discharge planners at Humana to search for a suitable place for her at a skilled nursing home so that she could continue her recovery and receive rehabilitation therapy. J.A. 118-20 (Abou-Jaoude Dep. at 19-21) and Abou-Jaoude Dep. at 18, 22; see also Deposition of Frank Miller, M.D. ("Miller Dep."), R. 53, at 26 (the decision to discharge a patient from Humana hospital is always a medical decision made by physicians). These efforts were complicated by "a long-standing shortage of nursing home beds in Kentucky." J.A. 137 (Affidavit of Nancy Fred ("Fred. Aff.) ¶ 3). They also were complicated by the fact that repeated attempts to involve Ms. Johnson's family in the discharge planning process proved unsuccessful. Nancy Fred, the social worker in charge of Ms. Johnson's discharge plan, repeatedly tried to contact Ms. Johnson's family because she recognized that it was "real important" to "reach the next of kin" and keep them apprised of the progress of the discharge plan. J.A. 25, 35 (Deposition of Nancy Fred ("Fred Dep."), R. 10, at 30, 42). However, Ms. Johnson's mother "didn't seem to want to be involved in any decisions." J.A. 35 (Fred Dep. at 42). Similarly, Ms. Johnson's husband could not be located by Ms. Fred, or indeed by other family members, at relevant decision points. J.A. 19, 34-35 (Fred Dep. at 25, 42). Because "everybody else had absconded or eliminated themselves," Ms. Fred communicated with Ms. Johnson's aunt, petitioner Jane Roberts, as "the only family member left that [the hospital] could contact." J.A. 35-36 (Fred Dep. at 42-43).

In late July, Ms. Johnson was accepted for admission at Crestview Health Care Center ("Crestview"), a state-licensed skilled nursing home in Indianapolis, Indiana. Ms. Fred had expanded her search into Indiana, which is just across the river from Louisville, because of the shortage of facilities in Kentucky. J.A. 137 (Fred Aff. ¶ 3). Humana determined that Crestview was an appropriate placement for Ms. Johnson based on Ms. Fred's discussions with Jo Anna Nolte, a representative of Crestview, who stated that Crestview "was a skilled nursing facility, certified by the state certification agency; that they had the therapies that Mrs. Johnson could benefit from to work toward her rehabilitation," including speech therapy, physical therapy, and occupational therapy. J.A. 31-32 (Fred Dep. at 36-37); see also Deposition of Jo Anna Nolte ("Nolte Dep."), R. 18, at 61 (Crestview was certified by the State of Indiana to provide skilled nursing care, including to patients who required "heavy care"); Fred Dep. at 49 (Humana's "main consideration" was that the receiving facility be "certified for skilled nursing"). Ms. Fred also spoke "several times with Randy Gross, who was the director/administrator at Crestview." *Id.* at 38-39. She also discussed the prospective transfer with Dr. Abou-Jaoude, who "[made] sure [Crestview] was a skilled nursing facility." J.A. 121-22 (Abou-Jaoude Dep. at 29-30); J.A. 38-39 (Fred Dep. at 54-56).[4]

Ms. Fred attempted to contact Ms. Johnson's husband to discuss the potential transfer to Crestview, but was unsuccessful. J.A. 25-26, 34-35 (Fred Dep. at 31, 41-42). She then contacted petitioner, Ms. Johnson's aunt, who did not object to the transfer. J.A. 34-36 (Fred Dep. at 41-43). If petitioner *had* opposed the transfer, "[Humana] wouldn't have discharged [Ms. Johnson] to that facility." J.A. 36 (Fred Dep. at 43).

---

[4] Ms. Nolte testified that Ms. Fred told her that "she was getting a lot of pressure to discharge [Ms. Johnson] due to they knew they weren't going to get paid for this person." J.A. 42 (Nolte Dep. at 23); *see also* Nolte Dep. at 48 (Ms. Fred indicated that the alleged pressure was from the hospital, not from Ms. Johnson's physicians). Ms. Fred denies that she made any such statements to Ms. Nolte, and has stated that she "was under no pressure from any department of the hospital or physician to locate a nursing home placement for Wanda Johnson for financial reasons." J.A. 137-38 (Fred Aff. ¶¶ 5-7).

Ms. Johnson was "stable" during the two weeks prior to her discharge and certainly suffered from no emergency medical condition. J.A. 123 (Abou-Jaoude Dep. at 37). She developed a fever the day before the transfer, just as she had several times during her stay in the hospital, and her doctors performed their "routine workup," which included a chest x-ray, urinalysis, and blood work. J.A. 126-27 (Abou-Jaoude Dep. at 48-49). Because the urinalysis was cloudy and she had an elevated white blood cell count, the doctors suspected that she had yet another urinary tract infection. *Id.* They also suspected that she might have another bout of pneumonia based on a bronchial specimen. J.A. 128 (Abou-Jaoude Dep. at 50-51). They put her on Bactrim, a broad spectrum antibiotic, which treats urinary tract infections and had been used successfully to treat Ms. Johnson's pneumonia previously. *Id.* According to Dr. Abou-Jaoude, none of Ms. Johnson's doctors ever considered delaying the transfer because of the suspected urinary tract infection. J.A. 130 (Abou-Jaoude Dep. at 53).

Ms. Johnson was transferred to Crestview on July 24, 1992. All of her doctors concluded that she was sufficiently stable to warrant transfer on that date. J.A. 131 (Affidavit of David Richardson, M.D. ("Richardson Aff.") ¶ 5); J.A. 133 (Affidavit of Walid Abou-Jaoude, M.D. ("Abou-Jaoude Aff.") ¶ 4); J.A. 135 (Affidavit of Brian Harbrecht, M.D. ("Harbrecht Aff.") ¶ 4). Of even greater importance in connection with this case, it was plain that "she did not have an emergency medical condition on the date of her transfer." J.A. 103 (Miller Dep. at 30). Moreover, the undisputed evidence in this case is that urinary tract infections are routinely treated at skilled nursing facilities, including Crestview, and even can be treated on an outpatient basis. See, e.g., J.A. 83-84 (Deposition of Kambiz T. Karimi, M.D., R. 89, at 16); J.A. 87 (Deposition of Taiseer Shatara, M.D. ("Shatara Dep."), R. 90, at 20) (Crestview was capable

of managing a patient with a urinary tract infection and could modify antibiotic therapy if necessary); J.A. 110 (Deposition of John W. Stuy, M.D., Mar. 28, 1995 ("Stuy Dep."), R. 88, at 25). The discharge summary that Dr. Abou-Jaoude prepared for Ms. Johnson identified all of the medications that she was taking, including Bactrim for a urinary tract infection. J.A. 124-25 (Abou-Jaoude Dep. at 46-47); Ex. 4 to Abou-Jaoude Dep., at 4.

At the time of Ms. Johnson's discharge, her application for social security disability, including Kentucky Medicaid, was pending before the state agency. J.A. 39 (Fred Dep. 55-56); J.A. 137 (Fred Aff. ¶ 4). The physician who signed the discharge papers, however, was unaware of her financial status. J.A. 133 (Abou-Jaoude Aff. ¶ 5). Indeed, physicians at Humana Hospital "are typically not aware of a patient's payment source at the time of discharge." J.A. 135 (Harbrecht Aff. ¶ 5); J.A. 104 (Miller Dep. at 31-32). Moreover, as was true of Ms. Johnson, Humana Hospital often does not know a patient's ultimate ability to pay at the time of discharge because insurance coverage issues, public assistance applications, and lawsuits can take months to resolve, particularly in accident cases. *Id.;* see also Deposition of John Nord, R. 47, at 15-16 (it can take up to two years for a Medicaid application to be approved). Accordingly, the undisputed evidence is that Ms. Johnson's financial situation played no part in her physicians' medical decision to transfer her to a skilled nursing facility. J.A. 131 (Richardson Aff. ¶ 6); J.A. 133 (Abou-Jaoude Aff. ¶ 6); J.A. 135 (Harbrecht Aff. ¶ 6).

Ms. Johnson arrived at Crestview at approximately 5:30 p.m. on July 24, and was assessed by Charna Treser, the licensed practical nurse on duty. At approximately 6:00 p.m., Ms. Treser called Dr. Taiseer Shatara, M.D., who authorized Ms. Johnson's admission based on the information provided by Ms. Treser and the physician's con-

clusion "that [Ms. Johnson] was stable and that she was an appropriate candidate for nursing home placement." J.A. 88 (Shatara Dep. at 21); see also J.A. 85 (Shatara Dep. at 17) ("[B]ased on the information that was given to me at the time, I felt that the patient was stable enough"). Ms. Johnson also was seen that night by Lynnette Ferguson, Crestview's director of nursing, who noted that Ms. Johnson had an elevated temperature of 100.5 degrees at the time of her arrival, but did not consider this unusual for a new admission. Deposition of Lynnette Ferguson ("Ferguson Dep."), R. 19, at 24-25, 56. Ms. Ferguson concluded that Ms. Johnson was an appropriate patient to be cared for at Crestview. *Id.* at 52. When Ms. Treser completed her shift at 11:00 p.m., she recorded on her chart "that there were no signs or symptoms of distress for Ms. Johnson." J.A. 59 (Deposition of Charna Treser ("Treser Dep."), R. 92, at 69.

According to Ms. Johnson's chart, her temperature was next taken at 9:10 a.m. on July 25, at which time it was 105 degrees. Ferguson Dep. at 56. Ms. Ferguson contacted one of Crestview's doctors because of the elevated temperature and because Ms. Johnson was experiencing respiratory distress. *Id.* at 26. The doctor instructed her to send Ms. Johnson to the emergency room of Midwest Hospital ("Midwest") for an evaluation. *Id.* at 26-27. Ms. Johnson was admitted to Midwest and remained there for several months. The physician who admitted her, Dr. John W. Stuy, opined that the cause of her deterioration while at Crestview was "[e]ither the urinary tract infection that she was treated for was not covered, was not sensitive to the antibiotic that she was sent on transfer, or she developed another acute pulmonary infection." J.A. 112 (Stuy Dep. at 32). Dr. Stuy conceded that Ms. Johnson's condition was "substantially worse" when she was admitted to Midwest Hospital than when she had been discharged from Humana under physician's orders. Stuy Dep. at 76, 91-92. He also conceded that the transfer itself had not caused her to become ill. *Id.* at 75-76. His opinion was that she would have developed the same infection at Humana and at Crestview, but that the problem likely would have been addressed earlier in the hospital setting. *Id.* at 92-93.

Procedural History

On August 30, 1993, petitioner Jane Roberts, who is now Ms. Johnson's guardian, filed an action on her behalf under EMTALA, 42 U.S.C. § 1395dd, alleging that Humana violated EMTALA by transferring Ms. Johnson to Crestview pursuant to physician's orders when her condition was not stable. The complaint does not allege that Ms. Johnson's initial screening at Humana was inappropriate under EMTALA and the parties agree that Ms. Johnson had an emergency medical condition when she arrived at Humana's emergency room. The complaint also alleged that Humana violated the due process and equal protection clauses of the United States and Kentucky constitutions and was liable under state law for the negligence of Ms. Johnson's doctors. The Secretary of Health and Human Services did not seek any civil money penalties against either the hospital or its physicians in this case. Nor did Midwest Hospital, the downstream provider, assert its statutory right to bring a civil action against Humana to recover its costs of treating Ms. Johnson.

A. Humana moved for summary judgment in the district court. The district court initially denied Humana's motion with respect to the EMTALA claim. Pet. App. A26-A45. The court held that there was a genuine issue of material fact as to whether Ms. Johnson was stabilized before she was transferred to Crestview, based on the conflicting testimony of Ms. Johnson's treating physicians at Humana and the physician who later treated her at Midwest Hospital. *Id.* at A29-A36. The court also held that there was a genuine issue of material fact as to

whether Humana acted with an improper motive, based on the conflicting testimony of the Humana social worker and the Crestview representative concerning whether the social worker had indicated that she was under pressure to arrange a transfer for Ms. Johnson because of her financial status. *Id.* at A37-A39. The court relied on the Sixth Circuit's decision in *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990), for its conclusion that "the presence of an improper motive [is] an essential element in a claim for relief under [EMTALA]." Pet. App. A37. The court granted Humana's motion for summary judgment on the constitutional and state law negligence claims.

Humana moved for reconsideration on the EMTALA claim, arguing that there was no genuine issue of material fact as to causation because, irrespective of any improper motive on the part of the hospital, the decision to discharge Ms. Johnson was made by physicians who were not aware of her financial status. The motion for reconsideration was granted and the court entered judgment for Humana on the EMTALA claim. Pet. App. A48-A52.

B. Petitioner appealed the district court's ruling on the EMTALA and state law negligence claims and the Sixth Circuit affirmed. Pet. App. A1-A25. The court noted that there was a genuine issue of material fact as to whether Ms. Johnson was stable when transferred. *Id.* at A13. However, it held that the district court "properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA." *Id.* at A10. Although *Cleland* involved a claim of inappropriate screening, the court held that proof of improper motive is required "to make a case of inappropriate screening *or improper discharge*" under EMTALA. *Id.* at A11-A12 (emphasis added). Applying the improper motive test

to the facts of this case, the court noted that although there was evidence that "some representative of the hospital may have been acting with an improper motive," there was no genuine issue of material fact with respect to causation because "there is no evidence that this improper motive caused Dr. Abou-Jaoude to issue Johnson's discharge order." *Id.* at A15. Accordingly, the court of appeals affirmed the summary judgment on the EMTALA claim. *Id.* at A16. It also affirmed the summary judgment on the state law negligence claim, which is not at issue here.

SUMMARY OF ARGUMENT

A. The first sentence of the United States' brief (U.S. Br. 1) accurately describes what this case is about: it "concerns the requirements for establishing liability under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd." The United States, however, offers a theory of EMTALA liability that extends well beyond the narrow question directly posed by the Sixth Circuit's holding that EMTALA liability requires proof of improper motive in transferring or discharging a patient. The government argues that the statute imposes a federally-defined "objective standard of [medical] care," against which the federal courts should assess the adequacy of treatment provided to stabilize a patient's "medical condition." U.S. Br. 11. The government's response to the court of appeals' effort (shared by every other court of appeals that has addressed the issue) to prevent EMTALA from becoming "nothing more than a federal remedy for medical malpractice," (Pet. App. A12) is to assert that its opinion merely "represents a disagreement with Congress's decision" and is thus "of little import." U.S. Br. 13.

Under the government's apparent view of the statute, once a patient is brought into the hospital for an emergency condition, the hospital assumes a federal duty under EMTALA to ensure the stability of the patient's "medical

condition" prior to his or her release or transfer from the hospital under physician's orders. In embracing this expansive interpretation of the statute, the United States' brief illustrates why this Court should take advantage of this opportunity to resolve the critical and recurring question regarding the breadth of EMTALA.

The issue of whether EMTALA can be more reasonably confined than the Solicitor General proposes is critical because, if Congress has created a "federal malpractice statute" regulating all discharges by hospitals pursuant to physician's orders, then the federal government has asserted extraordinary authority to regulate the practice of medicine in the hospital setting. This is the type of arrogation of power by the federal government in an area traditionally regulated by the States where this Court has insisted that Congress evince its intention in language that admits of but one conclusion. See, e.g., *United States* v. *Bass*, 404 U.S. 336, 349 (1971).

In considering whether EMTALA has such a breathtaking sweep or is instead a gap-filling statute designed to impose novel obligations on hospitals—not to supersede state-law imposed responsibilities—the Court must examine the language of the statute against *Bass*'s fundamental rule of construction derived from principles of federalism. Judged against those standards, it is clear that EMTALA is not what the Solicitor General asserts it is. The language, structure and history of this statute reveal that it is not a revolutionary enactment; to the contrary, it imposes discrete and relatively narrow duties and is intended to interfere as little as possible with the operation of state law. See 42 U.S.C. § 1395dd(f).

B. For these reasons, the Court should reject the government's suggestion that EMTALA must be read expansively. Nevertheless, simply rejecting the government's interpretation will not resolve the question of how EMTALA should be applied in this particular case. To its credit, the court of appeals sought to impose a reasonable limitation on the statute that would protect patients from being "dumped" by hospitals for non-medical reasons, but still would ensure that EMTALA does not supersede state malpractice law in hospitals. The problem is that while the "motive" test adopted by the court below is consistent with Congress's obvious intent, it lacks support in any of the traditional sources of statutory construction. To be sure, it is a sensible solution to a difficult issue, but it is not the solution that Congress expressed in the statutory text. Respondent and the health care industry would welcome this rule of law, but neither can credibly argue that the Court should read it into the statute.

To the extent the Court accepts respondent's concession, it may set aside the judgment below on the ground that the statute will not bear the Sixth Circuit's construction. Simply setting aside the judgment below, however, would carry with it significant opportunity costs. This case squarely presents two alternative arguments for affirmance that have been adopted by other courts of appeals. This Court should address those alternative arguments for affirmance in order to spare patients and hospitals the necessity of expending scarce resources in litigating the bounds of EMTALA in cases that arise every day.

First, the record in this case is absolutely clear that all of the physicians involved with Ms. Johnson's treatment believed that her condition had stabilized and did not regard her urinary tract infection as a serious, much less an "emergency," medical condition. Thus, under the law in the Fourth, Fifth, Eighth, Ninth, Tenth and D.C. Circuits, all of which require an EMTALA plaintiff to prove that the hospital had actual knowledge of the patient's emergency condition before any duty arises under EMTALA, summary judgment in favor of the hospital was clearly appropriate in this case. Because that interpretation of the statute is compelled by the language,

structure and history of EMTALA, the Court should apply it in this case as an alternative ground to affirm.

Second, there is no question that the hospital in this case properly screened Ms. Johnson and fully treated the emergency condition caused by her tragic accident. The issue then is whether EMTALA imposes any continuing duties on the hospital once the emergency treatment has been completed. Under the law in the Fourth and Tenth Circuits, it is clear that the hospital's duties under EMTALA lapsed well before her transfer pursuant to physician's orders to a skilled nursing facility and that state tort law became the sole source of potential liability. Again, this alternative basis for affirmance is grounded in the language and purpose of the Act and thus the Court should apply it here rather than prolong a lawsuit that has no merit.

Review of these alternative arguments is particularly warranted given the government's position that it has broad authority to regulate hospital treatment decisions under federal standards. If that interpretation is wrong—and respondent believes strongly that it is—then the Court should act promptly before the bureaucratic machinery of the Department of Health and Human Services undertakes to enforce its vision of EMTALA. At a minimum, the Court should make clear that it was not Congress's expressed intent in enacting EMTALA to occupy the field of medical malpractice in the emergency hospital setting.

ARGUMENT

It is common ground among the parties and their respective *amici* that the immediate focus of Congress in enacting EMTALA was to prevent the practice of patient dumping. Congress was rightly offended that some hospitals would turn individuals away without providing any initial examination or without providing immediate treatment when indicated for reasons having nothing to do with the patient's medical condition. See H.R. Rep.

No. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 605. Respondent is acutely aware of the problems that animated Congress's action because the University of Louisville Hospital has for years been the transferee hospital for hundreds, if not thousands, of patients that other hospitals refused to admit and to treat. As in this case, respondent has always admitted all patients, screened them, treated them, and when in the judgment of the treating physicians the time was right, arranged for the patients' discharge or their transfer to other, more appropriate treatment settings.

Where the parties disagree is in determining just how broadly Congress in enacting EMTALA imposed duties on essentially all of the nation's hospitals.[5] The United States asserts broadly that "the hospital's duty is to provide sufficient treatment 'to stabilize the medical condition,' " of the patient. U.S. Br. 11. This is a duty in the context of this case that apparently extends months after the patient is admitted to the hospital and has received extraordinary medical care. Moreover, this duty apparently applies to a discharge decision made by physicians who unanimously agree that the patient no longer faces a medical emergency. The unmistakable effect of this argument is that federal law overlays and effectively supersedes state law with respect to much, if not most, medical treatment decisions arising out of an emergency care patient's transfer or discharge from a primary care facility.

Without question, Congress has the authority to achieve this objective under its Commerce and Spending powers, but it is difficult to read 42 U.S.C. § 1395dd(b)(1), which is the only portion of this statute directly at issue here, to accomplish the sweeping effect the United States proposes. The statute is limited by its terms to the situa-

[5] The Solicitor General suggests that EMTALA applies to 99 percent of all hospitals. U.S. Br. 2 n.1. Respondent does not doubt the accuracy of that estimate.

tion where an individual "comes to a hospital" and the hospital, after a mandatory screening examination, actually "determines" that "an emergency medical condition" exists. In that precise circumstance EMTALA requires the individual's medical condition to be "stabilize[d]" through medical treatment.

Although this language cannot be read to include an element of "motive" as a requirement for liability, neither can it be stretched as the United States would read it to include a roving commission to the Department of Health and Human Services to seek out transfers and discharges of patients that failed to meet a "federal" standard of care, even though the physicians believed that there was no serious, much less emergency, condition present in the patient and even though the patient had been admitted and treated at the hospital for more than two months.

What makes the United States' effort to read so much into this statute particularly troublesome is its failure even to acknowledge the serious violence to principles of federalism that is embodied in its approach. The cavalier suggestion that these concerns are "of little import" (U.S. Br. 13) seems hollow given the lack of clear evidence of congressional intent, which this Court requires before assuming that traditional state regulation will be superseded by federal authority.

Accordingly, respondent begins where the Solicitor General declines to tread—an analysis of the relevance of the fundamental canon of statutory construction that requires clear intent by Congress before the Court radically alters the "balance of power" in an area, like medical malpractice, that has historically been the exclusive preserve of the States. Then, respondent will show that the United States' argument does serious harm to those principles and thus should be rejected. Respondent next will examine the Sixth Circuit's well-meaning, but ultimately unsupportable effort to maintain the proper balance of power between federal and state law in the emergency care setting. Respondent will offer two alternative rationales that the Court should consider, both of which would have been employed by more than one other court of appeals and both of which would unquestionably warrant affirmance of the judgment in this case. By entertaining these two arguments, the Court will provide important guidance to the federal courts and prevent EMTALA from allowing every run-of-the-mill malpractice action arising in the hospital setting from becoming a lawsuit in federal court.

I. EMTALA DOES NOT FUNDAMENTALLY ALTER THE CONSTITUTIONAL BALANCE BETWEEN FEDERAL AND STATE RELATIONS BY CREATING A FEDERAL STANDARD OF CARE FOR MEDICAL DIAGNOSIS AND TREATMENT FOR ALL PATIENTS WHO ENTER A HOSPITAL'S EMERGENCY ROOM.

A. When construing a federal statute such as EMTALA, ordinarily it is appropriate to start with the language and structure of the statute, and then construe that language using other traditional tools of statutory interpretation. In this case, however, it is important to take a step back and consider some first principles because Congress was not writing EMTALA on a blank slate. Rather, Congress undertook to legislate in an area —the physician-patient relationship—that traditionally has been regulated exclusively by state law. Accordingly, this case implicates fundamental principles of federalism that must be examined in order to put the task of interpreting EMTALA into its proper context.

This Court has long followed the "ordinary rule of statutory construction that if Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.' " *Will* v. *Michigan Dept. of State Police*, 491 U.S. 58, 65

(1989), quoting *Atascadero State Hospital* v. *Scanlon*, 473 U.S. 234, 242 (1985). This principle, which is deeply rooted in concepts of federalism, is "nothing more than an acknowledgment that the States retain substantial sovereign powers under our constitutional scheme, powers with which Congress does not readily interfere." *Gregory* v. *Ashcroft*, 501 U.S. 452, 461 (1991). Although Congress may alter the balance of federal-state power, "it is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrides" state sovereignty. *Atascadero*, 473 U.S. at 243.[6]

The Court has applied this clear statement requirement in determining whether Congress intended to expand the role of the federal government vis-a-vis the States in an area of traditional state responsibility. In *United States* v. *Bass*, 404 U.S. 336 (1971), for example, the Court narrowly construed the scope of a federal criminal statute because the broad reading would have "render[ed] traditionally local criminal conduct a matter for federal enforcement." *Id.* at 350. The Court invoked the principle that "unless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance" in an area of traditional state concern such as criminal jurisdiction. *Id.* at 349. The Court explained that "[i]n traditionally sensitive areas, such as legislation affecting the federal balance, the requirement of a clear statement assures that the legislature has in fact

[6] This clear statement rule is consistent with the principle used in preemption cases that where intrusion into an area of traditional state responsibility is involved, the Court will narrowly construe the preemption provision to go no further than necessary to effectuate the federal purposes. *See, e.g., Cipollone* v. *Liggett Group, Inc.*, 505 U.S. 504, 518 (1992) (plurality) ("[W]e must construe these provisions in light of the presumption against the pre-emption of state police power regulations."); *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (this Court "start[s] with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress").

faced, and intended to bring into issue, the critical matters involved in the judicial decision." *Id.*

As this Court has recognized, tort law, like criminal law, is a classic area of traditional state responsibility. See, e.g., *Silkwood* v. *Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (acknowledging "the States' traditional authority to provide tort remedies to their citizens"). Moreover, the primacy of the States in addressing matters of public health and safety repeatedly has been recognized by this Court. See, e.g., *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 475 (1996) (noting "the prominence of the States in matters of public health and safety"); *Hillsborough County* v. *Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985) ("[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern"). Accordingly, because Congress drafted EMTALA against the backdrop of a well-established body of state tort law governing medical malpractice, the statute should only be read to expand the role of the federal government vis-a-vis the States in the area of the physician-patient relationship if the clear statement requirement is satisfied. Indeed, given the Court's consistent adherence to the clear statement requirement, it should be presumed that Congress was aware when it drafted EMTALA that any intent to "federalize" the area of medical malpractice law had to be clearly and unambiguously expressed in the statutory language.

B. The clear statement requirement provides the background against which the Court must evaluate the United States' provocative position that EMTALA "imposes an objective standard of care" for medical diagnosis and treatment, which requires a hospital to diagnose, treat and stabilize a "medical condition" once a patient is admitted for emergency care. U.S. Br. 11; see also *id.* at 12 (Congress chose to address the problem of patient dumping "through imposition of a substantive standard of medical care"). The essential flaw in the United States' argu-

ment is that none of the language of EMTALA comes close to satisfying the clear statement requirement. Congress simply provided no hint in the statutory language—much less an "unmistakably clear" statement—that it intended fundamentally to alter the federal-state balance by creating a substantive federal malpractice standard.

The Court therefore should reject the United States' sweeping interpretation of EMTALA—an interpretation that is not advanced by petitioner and, not surprisingly, has unanimously (and emphatically) been rejected by every court of appeals to consider it. See *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) ("[W]e cannot agree that [EMTALA] creates a sweeping federal cause of action with respect to what are traditional state-based claims of negligence or malpractice"); *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996) ("EMTALA does not create a cause of action for medical malpractice"); *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 138, 142 (4th Cir. 1996) ("The other circuit courts are universally in accord on the need to distinguish EMTALA claims from standard claims of negligence and misdiagnosis"); *Marshall* v. *East Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998) ("We agree with the other courts which have interpreted EMTALA that the statute was not intended to be used as a federal malpractice statute"); *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (the language of EMTALA "precludes resort to a malpractice or other objective standard of care"); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) ("[E]very court that has considered EMTALA has disclaimed any notion that it creates a general federal cause of action for medical malpractice in emergency rooms"); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("The statutory language of the EMTALA clearly declines to impose on hospitals a national standard of care in screening patients"); *Repp* v.

Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994) ("[W]e believe that the language of section 1395dd(a) precludes the adoption of a standard tantamount to a federal malpractice statute"); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) ("Section 1395dd(a) is not designed to redress a negligent diagnosis by the hospital; no federal malpractice claims are created"). See also, *Owens* v. *Bellevue Hosp. Ctr.*, No. 95-9016, 1996 WL 134227 (2d Cir. Mar. 25, 1996) (unpub.) ("EMTALA is not intended to provide a federal remedy for medical malpractice"). The suggestion by the government that these rulings "merely represent[] a disagreement with Congress's decision" and therefore are "of little import" should be rejected in this Court. U.S. Br. 13.

The text of EMTALA contains no "clear statement" that Congress intended to create a substantive federal standard of care for the diagnosis and treatment of patients whenever they are transferred or discharged from a hospital under physician's orders. To the contrary, the language of 42 U.S.C. § 1395dd(b)(1) is extremely narrow. It does not purport to impose duties on the hospitals in general. The statute's duties are triggered only by having an individual "come[] to a hospital." Even then, the federal statute does not purport to impose broad responsibilities on the facility. Under subsection (a) a screening examination is required, but there is no dispute that a proper examination was made when Ms. Johnson "[came] to the emergency department" in critical condition. But the statute does not pointedly impose upon the hospital a duty to ascertain the patient's condition and treat it non-negligently. Instead, no treatment obligation arises at all unless and until the hospital actually "determines" that "an emergency medical condition" exists. Only then is there a duty to provide "such treatment as may be required to stabilize the medical condition." Of course, the condition that must be stabilized is not some

unknowable condition that may arise, but rather the specific "emergency medical condition" that is mentioned earlier in subsection (b).

Viewed against the existing common law obligations imposed by the States, it is easy to understand how this language can and should be read narrowly, not broadly as the United States asserts. First, the statute creates a duty to enter into a physician-patient relationship in the hospital setting. By requiring hospitals to accept patients for screening and diagnosis, federal law eliminated a loophole in state law that had allowed hospitals to turn away patients without having to confront possible malpractice claims. See *supra*, at 5. Second, the effect of creating the relationship, by itself, triggered state common law obligations to provide non-negligent diagnosis and care. There is nothing in the statute that remotely suggests Congress found state law inadequate on this count or that Congress felt any need to supplement, much less supplant, state law. Finally, the only real "treatment" duty was to "stabilize" the patient's *emergency* medical condition. There is no guarantee of a quality of care or the requirement of a continuing duty beyond what was necessary to get the patient past the immediate crisis. In sum, EMTALA is a focused statute that imposes limited responsibilities on hospitals and nothing in its language or purpose supports the suggestion that it imposes "a substantive standard of medical care" that arises regardless of the physician's determination of the patient's condition or regardless of whether the patient's emergency condition has long since lapsed.

The United States' principal textual support for its position is that Congress incorporated a "reasonableness" standard in some of the definitions of key terms that appear in EMTALA. U.S. Br. 16-18. For example, EMTALA defines "to stabilize" as to provide such medical treatment as may be necessary to assure, "within *reasonable* medical probability," that the patient will not

materially deteriorate. 42 U.S.C. § 1395dd(e)(3)(A) (emphasis added). Similarly, an "emergency medical condition" is defined as a condition "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could *reasonably* be expected to result in" serious jeopardy to the patient's health or other adverse consequences. 42 U.S.C. § 1395dd(e)(1)(A) (emphasis added).

The short answer to the United States' argument is that Congress's use of the term "reasonable" in two definitions that appear in EMTALA falls far short of an "unmistakably clear" statement that Congress intended to create a federal standard of care and thereby inject federal courts into the difficult business of adjudicating all medical malpractice claims arising in a hospital setting. At a bare minimum, if Congress had intended to establish a federal standard of care, Congress would have addressed that issue directly in a substantive provision in the statute, rather than indirectly in two definitions.

Even if the statutory definitions are probative on this issue, they arguably cut the other way because EMTALA does not uniformly define a hospital's obligations in terms of "reasonableness." As the United States concedes, "the Act does not define the term 'appropriate medical screening examination' " at all. U.S. Br. 3. This omission is significant because if Congress had intended to enact a substantive standard of care, it presumably would have done so for hospitals' *screening* obligation as well as their *stabilization* obligation. Congress's failure to establish any standard for "appropriate medical screening," a principal obligation under the statute, can only mean that it did not intend to establish a federal standard of care regarding the quality of the screening rather than the fact of screening. Similarly, refusal to stabilize a known emergency medical condition goes to the question of pro-

viding any treatment rather than treatment that may have constituted malpractice.

The United States' textual argument also comes up short because it cannot explain the drafting of the statute's provision for administrative sanctions against hospitals and physicians, which applies to those who "*negligently*" violate the Act. 42 U.S.C. § 1395dd(d)(1). If, as the United States argues, the definitions and substantive obligations of EMTALA incorporate a "reasonableness" standard of care, then EMTALA is a classic negligence statute. That is, the statute by definition can only be violated by "negligent" conduct. Under that reading, however, Congress's use of the term "negligently" in the administrative sanctions provision is superfluous and redundant, contrary to the well-established canon of statutory construction that a statute should be read "with the assumption that Congress intended each of its terms to have meaning." *Bailey* v. *United States*, 516 U.S. 137, 145 (1995). See also *United States* v. *Nordic Village, Inc.*, 503 U.S. 30, 36 (1992) (citing "the settled rule that a statute must, if possible, be construed in such fashion that every word has some operative effect"); *Platt* v. *Union Pac. R.R. Co.*, 99 U.S. 48, 58 (1878) ("[T]he admitted rules of statutory construction declare that a legislature is presumed to have used no superfluous words"). Therefore, Congress's use of the phrase "negligently" in the administrative sanctions provision must be read to have some meaning, which necessarily suggests that the substantive provisions of the Act do not already embody a "reasonableness" or "negligence" standard of care.[7]

[7] The United States concedes that EMTALA's private right of action provision "does not itself specify 'negligence' or any other standard to govern such an action." U.S. Br. 21 n.8. It nevertheless argues that it "believe[s] that the EMTALA provisions cited above that define a hospital's obligations in terms of reasonableness make clear that a private suit based on an asserted violation of Section 1395dd(b) must rest *at least* on an allegation of negligence with respect to the duties imposed by those provisions." *Id.* (emphasis added). The government's suggestion that it "believes" EMTALA's private right of action provision imposes a standard of care that is something more than negligence, without making any attempt to identify what that standard of care is, simply demonstrates that EMTALA does not set forth *any* standard of care with "unmistakable" clarity.

Finally, the United States wholly fails to address EMTALA's preemption provision, which provides that "[t]he provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). This preemption provision is narrow and, on its face, gives the widest possible scope to existing state law, which includes the well-established body of state malpractice law. This provision makes plain that Congress did not intend to preempt or displace that body of law by imposing a federal standard of care. By the same token, this provision is hardly consistent with an intent on the part of Congress fundamentally to alter the federal-state balance by creating a federal standard of care that parallels or overlays existing state standards of care. At the very least, this provision provides further evidence that the "clear statement" rule is not satisfied in this case.

Moreover, the legislative history of EMTALA contains no hint that Congress intended to create a federal malpractice statute. The few general statements from the Senate floor debates cited by the United States hardly imply, much less establish, that Congress intended fundamentally to change the federal-state balance by creating a federal malpractice statute. See U.S. Br. 25-26. To the contrary, the United States' anemic discussion of the legislative sources simply highlights the fact that they provide no affirmative support for its sweeping position. Indeed, the United States concedes that the House debates

on COBRA "rarely touched on EMTALA" and "[do] not clarify the instant question." *Id.* at 25 n.10. Congress's silence in the legislative history provides compelling evidence that it did not intend to change fundamental federal-state relations in this traditionally state-based area of tort law. See *Edmonds* v. *Compagnie Generale Transatlantique*, 443 U.S. 256, 266-67 (1979) ("[S]ilence [in legislative history] . . . while contemplating an important and controversial change in existing law is unlikely"); *Bass*, 404 U.S. at 350 ("[T]he legislative history provides scanty basis for concluding that Congress faced these serious questions and meant to affect the federal-state balance").

To the extent the snippets quoted by the government offer any useful insights, they support respondent's position that EMTALA is a gap-filling statute, i.e., the law merely imposes duties that were not imposed under state law at the time. Thus, Senator Durenberger characterized the problem in terms of a hospital "turn[ing] its back on an emergency medical situation." 131 Cong. Rec. 28,568 (1985). Similarly, Senator Dole described the hospital's duty as a "responsibility of providing an adequate first response to a medical crisis. . . ." *Id.* at 28,569. There is nothing in these expressions of intent by the bill's floor manager and co-sponsor to indicate that EMTALA would be a federal malpractice law that enforces continuing diagnosis and treatment responsibilities months after a patient's admission and regardless of whether the attending physicians' professional judgment is unquestionably that the patient no longer suffers from an emergency medical condition. Those are matters thoroughly regulated by state law and, contrary to the Solicitor General's suggestion, EMTALA does not clearly supersede the States' common law in these areas.

Respondent therefore urges the Court to follow the unanimous decisions of the courts of appeals that have held that EMTALA does not fundamentally alter the

federal-state balance in this traditional area of state concern by implementing a federal standard of care for hospitals that provide emergency medical treatment. These courts also correctly have recognized that interpreting EMTALA as a federal negligence or malpractice statute for hospitals would have enormous practical consequences. It effectively would convert every common law malpractice claim against a hospital concerning emergency medical treatment into an EMTALA claim that could be brought, in federal court, without regard to the amount in controversy. This would lead to a huge increase in federal court litigation involving private rights of action under EMTALA, as suggested by the already sizable docket of court of appeals decisions involving civil suits under EMTALA, most of which involved situations where the Secretary of Health and Human Services did not choose to pursue administrative sanctions and the courts ultimately dismissed the claims on the ground that they simply were malpractice claims that should be raised under state law. In sum, if the United States' position were to prevail, hospitals would be uniquely subject to malpractice claims in federal court, even where essentially the same claims could be brought and historically have been brought in state court.

Interpreting EMTALA as a negligence statute also would dramatically change its nature and scope, and divorce it from Congress's focus on patient dumping. Under the various limiting principles applied by the courts of appeals, federal courts largely have avoided any inquiry into, or second-guessing of, the substance of medical judgments made by hospitals and physicians. If, however, EMTALA imposes a federal standard of care for medical diagnosis and treatment, such inquiries would be unavoidable. Indeed, federal courts would have to develop a substantive federal common law of medical malpractice in the context of emergency treatment. This would effectively transform the Act from one aimed at

preventing the problem of patient dumping to one concerned with punishing hospitals and physicians for substantive errors in the physicians' diagnosis and treatment of emergency room patients. EMTALA civil suits would therefore involve the same expert-intensive, after-the-fact inquiries into the soundness of medical decisions that characterize malpractice suits brought in state courts. As the courts of appeals have recognized, this expansive role for EMTALA cannot be squared with the narrow anti-dumping concerns that motivated Congress to enact the statute. Accordingly, this Court should reject the United States' interpretation.

II. ALTHOUGH THE COURT OF APPEALS' MOTIVE TEST LACKS A CLEAR STATUTORY ANCHOR, THE COURT SHOULD CONSIDER ALTERNATIVE GROUNDS FOR AFFIRMANCE THAT WILL REINFORCE THE UNIFORM RULE IN THE COURTS OF APPEALS THAT EMTALA SHOULD BE CONSTRUED NARROWLY TO PRESERVE STATE LAW REGULATING THE QUALITY OF MEDICAL CARE IN HOSPITALS.

If this Court rejects the United States' position, the question remains as to how a hospital's duties under EMTALA should be defined to ensure that the statute does not become a vehicle for raising mere malpractice claims in federal court. That was certainly the goal of the Sixth Circuit both in this case and in *Cleland*, and to that end, the court of appeals incorporated a "motive" test as part of the private cause of action under EMTALA. Under this view a hospital could be liable only if its refusal to provide a screening examination or to provide appropriate medical care to stabilize a patient's emergency condition were improperly motivated, either by concerns for the patient's indigence or by "prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the

patient; disapproval of the patient's occupation; or political or cultural opposition." Pet. App. at A9-A10 (quoting *Cleland*, 917 F.2d at 272).

At the end of the day, respondent cannot defend the judgment on this ground. The statute, by its terms, does not require proof of motive. Instead, the language of the statute, albeit not a model of clarity, is couched in objective terms that are inconsistent with implying a subjective motive standard. The legislative history does not clearly support this approach and the Secretary of HHS has rejected the interpretation. The principal argument that supports this rule is that Congress did not intend to supersede state law when it enacted EMTALA and a motive requirement preserves state law to the maximum extent feasible.

The court's goal is laudatory and its conclusion is consistent with principles of federalism, but its method is not one that Congress adopted and no good purpose would be served by attempting to defend that interpretation. Nevertheless, for reasons that follow, it is absolutely plain that the summary judgment entered in respondent's favor in this case would have been entered on this identical record in virtually every other circuit court of appeals, but on either of two different legal theories, both of which were pressed below. Neither of these theories was addressed because *Cleland* was the law of the Sixth Circuit, but it is plain that, if the Sixth Circuit had rejected either of the alternative theories, then such a decision would warrant review by this Court for essentially the same reason this case was appropriate for review—a split in the circuit courts of appeals on a recurring legal issue of federal law. Accordingly, nothing prevents this Court from considering both of these issues now.[8]

---

[8] This Court repeatedly has held that the prevailing party may "defend its judgment on any ground properly raised below whether

Moreover, compelling reasons exist to entertain alternative grounds for affirmance in this particular setting. The Court has been particularly inclined to entertain alternative grounds where the issues are squarely presented and addressing them would serve the interest in efficient judicial administration. In *Blonder Tongue Labs., Inc.* v. *University of Illinois Found.*, 402 U.S. 313, 320-21 n. 6 (1971), for example, the Court addressed an issue not raised in the petition for certiorari because the issue was "a significant one" and "[had] been fully briefed and argued by the parties." Those factors are present here. For the Court to vacate and remand on the motive issue will hardly achieve anything because the court of appeals, which clearly is in search of a limiting principle for EMTALA, will almost certainly adopt one of the two alternative approaches outlined below. For this Court to address either or both issues would certainly conserve scarce judicial resources. The issue is posed and petitioner can present her arguments in response in her reply brief. If she requires additional pages or time, respondent certainly would have no opposition to either request.

More broadly, there are few statutes that have generated nearly so many court of appeals decisions all in search of limiting principles to ensure that EMTALA does not become a litigation-creating machine. Each of those courts has struggled to discern a textually-based rationale for accomplishing Congress's objective of ending the practice of patient dumping without divesting States of their traditional regulatory authority.

---

or not that ground was relied upon, rejected, or even considered by the District Court or the Court of Appeals." *Washington* v. *Yakima Indian Nation*, 439 U.S. 463, 476 n.20 (1979). Respondent properly raised both of the proposed alternative grounds in the courts below. *See infra*, nn. 9 & 12. In any event, the Court has inherent authority to consider issues that were not presented in the petition for certiorari and not raised in the courts below. *Vance* v. *Terrazas*, 444 U.S. 252, 258-59 n.5 (1980); *Dandridge* v. *Williams*, 397 U.S. 471, 475-76 n.6 (1976).

While the Court certainly expected to decide only the narrow motive issue posed by petitioner, this is the first case under EMTALA that this Court has chosen to review and the case provides a significant opportunity for the Court to examine the statute completely and to adopt an interpretation that achieves Congress's objectives without allowing EMTALA to expand beyond its appropriate boundaries. Nor is respondent offering these alternative rationales in a vacuum. It is the United States that has suggested the Court might use this case broadly to opine about the nature of the duties hospitals must assume under EMTALA by accepting federal monies. The government's position should be rejected, and the most effective way to halt the inevitable creep that this statute will undergo if HHS's enforcement efforts are left unattended is for this Court to declare that either or both alternative interpretations offered below in support of the judgment are correct. Accordingly, the Court should consider respondent's alternative grounds for affirmance in the unusual circumstances posed by this case. As respondents demonstrate now, the courts of appeals have derived at least two limiting principles from the language, structure, and purpose of the statute. This a suitable vehicle for the Court to recognize either or both of these limiting principles, each of which provides a clear alternative ground for affirming the judgment below.

III. THE JUDGMENT BELOW SHOULD BE AFFIRMED BECAUSE RESPONDENT WAS UNDER NO DUTY TO STABILIZE MS. JOHNSON SINCE HER TREATING PHYSICIANS DID NOT HAVE ACTUAL KNOWLEDGE THAT SHE WAS SUFFERING FROM AN EMERGENCY MEDICAL CONDITION AT THE TIME THEY ORDERED HER TRANSFER.

Several courts of appeals, including the court below, have held that EMTALA does not impose a duty on hospitals to stabilize a patient under 42 U.S.C. § 1395dd(b), or to stabilize a patient prior to transfer under 42 U.S.C.

§ 1395dd(c), unless the treating physicians have actual knowledge that the patient has an emergency medical condition that is in an unstable state. See *Marshall* v. *East Carroll Parish Hosp.*, 134 F.3d 319, 325 (5th Cir. 1998); *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139, 145 (4th Cir. 1996); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1140 (8th Cir. 1996); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1259 (9th Cir. 1995); *Urban by and Through Urban* v. *King*, 43 F.3d 523, 525-27 (10th Cir. 1994); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) ("If the emergency nature of the condition is not detected, the hospital cannot be charged with failure to stabilize a known emergency condition"). This argument has clear support in the plain language of the statute, is consistent with the concerns that Congress articulated in the legislative history, and properly distinguishes actions under EMTALA from actions under state malpractice and negligence statutes. Because the undisputed evidence in this case is that Ms. Johnson's treating physicians unanimously concluded that she was stable and did not have an emergency medical condition at the time of her transfer, this theory provides a clear alternative ground for affirming the judgment below.[9]

---

[9] This argument was properly preserved in the courts below. Respondent argued to the district court in its motion for summary judgment that "[a] necessary prerequisite of the hospital's duty to stabilize is the hospital's knowledge of the patient's emergency medical condition, gleaned from the medical screening." Memorandum in Support of Defendant Galen of Virginia, Inc. d/b/a University of Louisville Hospital's Motion for Partial Summary Judgment ("Respondent's Summary Judgment Memorandum"), R. 63, at 7 (citing *Cleland*). *See also id.* ("Plaintiff's burden is to show that the Hospital knew that Ms. Johnson had an emergency medical condition on the date of her discharge in order to show that the Hospital breached its duty to stabilize prior to her transfer to a nursing home"); *id.* at 8 ("The hospital's duty to stabilize arises only after it ascertains from the initial screening that an individual *has an emergency medical condition*") (emphasis in original).

Respondent raised this same argument on appeal. In its Sixth Circuit brief, respondent quoted the holding of the court in *Vickers* v. *Nash Gen. Hosp.*, 78 F.3d 139, 145 (4th Cir. 1996), that "'a hospital must actually perceive the seriousness of the medical condition and nevertheless fail to act to stabilize it.'" Brief of Appellee, at 15. Respondent then argued that "[i]n this case, Johnson's treating physicians 'perceived' that Johnson was stable, and believed that the transfer to Crestview was appropriate." *Id.* at 16.

The duty to stabilize a patient under 42 U.S.C. § 1395dd(b) applies when an individual comes to a hospital "and the hospital *determines* that the individual has an emergency medical condition." (emphasis added). The most natural reading of this statutory language is that the duty to stabilize a patient cannot arise unless the treating physicians at the hospital actually diagnose or detect the emergency medical condition, *i.e.*, unless the hospital has actual knowledge of the medical emergency. See *Vickers*, 78 F.3d at 145; *Summers*, 91 F.3d at 1140; *Urban*, 43 F.3d at 526; *Gatewood*, 933 F.2d at 1041. Once the hospital becomes aware of an emergency condition, however, the stabilization duty is unequivocally triggered and the hospital is required to act on its knowledge by stabilizing the patient. If the hospital fails to stabilize a *known* emergency condition, i.e., the hospital acts in conscious disregard of its knowledge of an emergency medical condition, then EMTALA's stabilization requirement is violated. Similarly, because the transfer requirements of 42 U.S.C. §§ 1395dd(c) apply only when a patient "has an emergency medical condition which has not been stabilized" within the meaning of § 1395dd(b), the transfer requirements are not triggered unless the hospital has actual knowledge of an emergency condition that requires stabilization.

The court in *Vickers* explained that this reading of the statutory language properly distinguishes a claim under EMTALA from a malpractice claim:

> On its face, [42 U.S.C. § 1395dd(b)] takes the actual diagnosis as a given, only obligating hospitals to stabilize conditions that they actually detect. . . . The Act does not hold hospitals accountable for failing to stabilize conditions of which they were not aware, or even conditions of which they should have been aware. [citation omitted] EMTALA would otherwise become coextensive with malpractice claims for negligent treatment.

78 F.3d at 145. The principle that the physician's actual diagnosis must be taken "as a given" under EMTALA identifies the critical distinction between EMTALA and state malpractice actions. Under the plain language of the statute, EMTALA imposes a duty on hospitals to treat patients when a physician "determines" or has actual knowledge that the patient has an emergency condition, not when a physician merely "should have known" that the patient has an emergency condition.

This interpretation of the statutory language is most consistent with the anti-dumping concerns that motivated Congress to enact the statute. If the physician actually knew that the patient had an emergency medical condition, and acted in disregard of that knowledge by refusing to stabilize the patient, then the hospital engaged in "dumping" and violated EMTALA. If, instead, the physician did not know but arguably "should have known" of the emergency medical condition, this may be a matter for state malpractice law, but is not "dumping" and hence does not constitute a violation of EMTALA. In short, Congress addressed its concerns about patient "dumping" by enacting a statute that provides a cause of action against hospitals when physicians refuse to treat patients whom they *know* have emergency medical conditions, not when they merely make mistakes and fail to diagnose such conditions in the first instance.[10]

[10] The actual knowledge requirement imposed by a majority of the courts of appeals is consistent with the fact that Congress required "negligence" for the imposition of administrative sanctions by the Secretary of Health and Human Services, but did not require negligence under the private right of action provision. For purposes of determining whether an injured patient is entitled to compensation, it makes sense to impose liability when a physician knows of an emergency medical condition and fails to act on this knowledge. For purposes of determining whether administrative sanctions against individual physicians and/or hospitals are appropriate, however, Congress reasonably concluded that carelessness would be an appropriate inquiry. In any event, it is difficult to draw comparisons between the administrative sanctions and private right of action provisions of EMTALA because they were designed to address different actors.

Under an actual knowledge test, the hospital's motive for failing to treat a patient can be relevant for purposes of establishing liability, but proof of an improper motive is not *required*. Motive evidence, when it exists, can be highly probative and helpful to the trier of fact. For example, if a plaintiff presents evidence that the physician was aware of the patient's emergency medical condition, but refused to treat it *because the patient was indigent*, this would establish a classic instance of dumping and hence a clear violation of EMTALA. Thus, motive evidence can play a role in establishing liability because it can shed light on the question whether a hospital acted in disregard of actual knowledge of a medical emergency. But proof of an improper motive is not *required* under EMTALA. The essence of a violation is failure to stabilize a known emergency medical condition. Once that has been established, the trier of fact need not determine the hospital's precise motive for failing to treat the patient.

Finally, as the court noted in *Urban*, an actual knowledge requirement does not create an incentive for physicians to "deliberately fail to diagnose emergency medical conditions in an effort to avoid liability under [EMTALA]." 43 F.3d at 526. EMTALA expressly requires hospital emergency rooms to perform appropriate medical screenings. *Id.* at 527. In addition, physicians and hospitals can be held liable under state malpractice laws if physicians fail properly to diagnose patients. *Id.*

Since EMTALA does not supplant or affect state malpractice laws, it does not alter physicians' powerful incentives to diagnose patients correctly.

There is no dispute in this case that Ms. Johnson's physicians unanimously concluded that she was stable and did not have an emergency medical condition at the time of her transfer to Crestview. Her treating physicians each submitted an affidavit stating that, in their respective medical opinions, Ms. Johnson was stable when she was transferred to Crestview. J.A. 131 (Affidavit of David Richardson, M.D. ("Richardson Aff.") ¶ 5); J.A. 133 (Affidavit of Walid Abou-Jaoude, M.D. ("Abou-Jaoude Aff.") ¶ 4); J.A. 135 (Affidavit of Brian Harbrecht, M.D. ("Harbrecht Aff.") ¶ 4). See also J.A. 103 (Miller Dep. at 30) ("In my opinion, she did not have an emergency medical condition on the date of her transfer"). Moreover, none of Ms. Johnson's doctors ever considered delaying the transfer because of the suspected urinary tract infection. J.A. 130 (Abou-Jaoude Dep. at 53). Indeed, even the doctor who treated Ms. Johnson at Midwest Hospital conceded that her condition when she arrived at Midwest was "substantially worse" than when she had been discharged from Humana under physician's orders. Stuy Dep. at 76, 91-92. This testimony is uncontroverted, and makes plain that Ms. Johnson's physicians did not diagnose or have actual knowledge of an emergency medical condition prior to her transfer that gave rise to a duty to stabilize. Accordingly, Ms. Johnson's EMTALA claim must fail as a matter of law.[11]

---

11 The findings by the courts below that a genuine issue of material fact exists with regard to whether Ms. Johnson's condition was "stable" at the time of her transfer is legally irrelevant for at least two reasons. First, the question is what the physician's actual knowledge or perception was. Thus, whether that assessment was correct or not is just not "material" under EMTALA. Second, the question is not as both the courts below and the Solicitor General put it, whether Ms. Johnson was in a stable condition. The question is whether she had an "emergency condition" that required continued treatment. Here, again, the record is uncontroverted that Ms. Johnson's infections were not uncommon and that they did not preclude a transfer to a skilled nursing facility. In sum, the question whether Ms. Johnson's condition was in fact stable is simply not relevant to any legal issue under EMTALA.

IV. THE JUDGMENT BELOW SHOULD BE AFFIRMED BECAUSE EMTALA DOES NOT APPLY TO TREATMENT AND DISCHARGE DECISIONS OCCURRING AFTER A PATIENT'S INITIAL SCREENING AND STABILIZING TREATMENT.

At least two courts of appeals have held that EMTALA's duty to stabilize a patient only applies to emergency medical conditions that are diagnosed at the time of the patient's initial screening in the emergency room. Once those emergency medical conditions have been stabilized, the requirements of EMTALA are wholly satisfied and the statute does not impose any obligations with respect to further conditions or complications that may arise after the hospital admits the patient for treatment. After a patient's initial screening and stabilizing treatment, the hospital's duty to the patient is governed solely by state law. *Bryan* v. *Rectors and Visitors of Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996); *Collins* v. *DePaul Hosp.*, 963 F.2d 303 (10th Cir. 1992). This interpretation of EMTALA is supported by the plain language of the statute and its legislative history, and is consistent with principles of federalism. This argument provides a clear alternative ground for affirming the judgment below because it is undisputed that Ms. Johnson was properly screened by respondent as having an emergency medical condition in the form of life-threatening trauma injuries, admitted to the hospital, and stabilized for that condition through surgery and other treatment.[12]

---

12 This argument was properly preserved in the courts below. Respondent argued in the district court in its motion for summary judgment that "EMTALA applies first and foremost to a patient who comes to the hospital seeking treatment for an emergency medical condition." Respondent's Summary Judgment Memorandum,

In *Bryan*, the court rejected the EMTALA claim of a patient who was diagnosed by a hospital emergency room as having an emergency medical condition in the form of respiratory distress, admitted to the hospital, and treated for twelve days. At that time, the hospital determined through its internal procedures that no further efforts should be made to prevent the patient's death, which occurred eight days alter. 95 F.3d at 350. The court of appeals rejected the EMTALA claim brought by the patient's estate on the ground that the hospital had satisfied the requirements of EMTALA by admitting the patient and providing stabilizing treatment for 12 days. The court held that

> the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment.

Id. at 352; see also *id.* ("The stabilization requirement is thus defined . . . without any reference to the patient's long-term care within the system"). The court explained that

> [o]nce EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians. And, the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law that

---

at 4; *id.* ("Congress' purpose in enacting EMTALA was to ensure 'that patients with medical emergencies would receive *emergency care*'") (quoting *Thornton* v. *Southwest Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990)) (emphasis added). Respondent cited the same language from *Thornton* in its brief on appeal. Brief of Appellee, at 8.

> everyone agrees EMTALA was not intended to preempt.

Id. at 351. *Accord Collins*, 963 F.2d at 307 (rejecting EMTALA claim on the ground that the hospital complied with EMTALA by diagnosing the patient as having an emergency medical condition, placing him in the intensive care unit, and treating him for 26 days).

The standard applied by the Fourth and Tenth Circuits find clear support in the plain language of the statute. The duty to provide screening under 42 U.S.C. § 1395dd(a) applies only when a hospital "has a hospital emergency department" and an individual "*comes to the emergency department*" and requests an examination or treatment. (emphasis added). The duty to stabilize a patient under 42 U.S.C. § 1395dd(b) applies only when an individual "*comes to a hospital* and the hospital determines that the individual has an emergency medical condition." (emphasis added). Congress's specific references to the patient's initial arrival at the hospital strongly suggest that it meant for EMTALA to apply only when a patient suffering from a possible emergency condition makes initial contact with a hospital and attempts to obtain an evaluation and treatment. The primary concern of EMTALA, in other words, is emergency medical care, not every treatment and discharge decision that is made in the hospital setting simply because the patient happened to have been admitted initially into an emergency room.

The legislative history strongly supports this interpretation. Members of Congress repeatedly declared that the core evil addressed by the legislation is patient "dumping" by hospital *emergency rooms*, i.e., the practice of some emergency rooms of refusing *emergency medical care* to patients who cannot pay. See, e.g., H.R. Rep. No. 99-241, pt. 1, at 27 (1985), *reprinted* in 1986 U.S. Code Cong. & Admin. News, 42, 605 ("The [House Ways and Means] Committee is greatly concerned about the increaing number of reports that *hospital emergency rooms* are

refusing to accept or treat patients *with emergency conditions* if the patient does not have medical insurance") (emphasis added); 131 Cong. Rec. S 13,904 (daily ed. Oct. 23, 1985) ("We must put an end to certain unsafe practices, often referred to as 'patient dumping,' whereby a hospital, for purely financial reasons, *refuses to initially treat or stabilize an individual with a true medical emergency*") (statement of Sen. Dole) (emphasis added); *id.* ("Under the provision of this amendment, a hospital is charged *only with the responsibility of providing an adequate first response to a medical crisis*") (statement of Sen Dole) (emphasis added); 131 Cong. Rec. H 9503 (daily ed. Oct. 31, 1985) ("[I]t should be the national policy for hospitals and free standing emergency centers to provide high quality *emergency care* to all patients without discriminating on the grounds of economic status, color, race, religion, sex or national origin") (statement of Rep. Bilirakis) (emphasis added).

This reading of EMTALA is consistent with principles of federalism because it proceeds from the notion that EMTALA was not meant to duplicate state malpractice laws that govern established doctor-patient relationships, but instead was meant to fill a gap in state tort law, which generally does not impose on hospitals an obligation to treat patients in the first instance. As the *Bryan* court noted, EMTALA's "core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat." 95 F.3d at 351. See also *Gatewood*, 933 F.2d at 1041 (EMTALA "is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat"); *Brooks* v. *Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) (Congress enacted EMTALA to require hospitals to provide universal emergency care because "[u]nder traditional state tort law, hospitals are under no legal duty to provide this care").

This reading of EMTALA also is consistent with principles of federalism because it rejects the notion that EMTALA creates an unbounded federal duty on hospitals to provide long-term care to patients based on an as-yet-to-be developed national standard of care. As the *Bryan* court reasoned:

> Under [plaintiff's] interpretation, every presentation of an emergency patient to a hospital covered by EMTALA obligates the hospital to do much more than merely provide immediate, emergency stabilizing treatment with appropriate follow-up. Rather, without regard to professional standards of care or the standards embodied in the state law of medical malpractice, the hospital would have to provide treatment indefinitely—perhaps for years—according to a novel, federal standard of care derived from the statutory stabilization requirement. We do not find this reading of the statute plausible.

95 F.3d at 351. The test applied by the Fourth and Tenth Circuits limits the federal cause of action to decisions concerning the initial screening and treatment of patients with possible emergency conditions. It avoids "federalization" of the entire panoply of treatment and discharge decisions made by physicians caring for patients in hospitals, which include difficult and complex decisions concerning the transfer of patients, such as Ms. Johnson, who have severe and chronic conditions that can only be improved by rehabilitation in non-hospital settings.

Under the standard applied by the Fourth and Tenth Circuits, the judgment below plainly was correct. There is no dispute in this case that Ms. Johnson's physicians properly diagnosed the life-threatening trauma injuries that she presented in the emergency room, promptly admitted her to the hospital, and stabilized those injuries during her two month hospital stay. The uncontradicted testimony of her doctors is that she was "stable" throughout July and was moved to a "step-down unit" within the hospital. J.A. 116-18 (Abou-Jaoude Dep. at 15, 17); see also *id.* at 123

(Ms. Johnson was "stable" during the two weeks prior to her discharge). Moreover, Ms. Johnson's doctors initiated procedures to transfer her to a skilled nursing facility to begin the rehabilitation process because they concluded that she was "stable" and "making progress." J.A. 118-20 (Abou-Jaoude Dep. at 19-21) and Abou-Jaoude Dep. at 18, 22. Indeed, petitioner has never disputed that Ms. Johnson's initial injuries were stabilized during her two-month hospital stay. Petitioner's claim is that Ms. Johnson developed a *new* infection prior to her transfer that rendered her unstable. Under the test employed by the Fourth and Tenth Circuits, however, that new complication is irrelevant because EMTALA does not apply to the treatment and transfer decisions made by Ms. Johnson's physicians after her initial emergency condition was stabilized. Accordingly, under that test, the summary judgment plainly was appropriate.[13]

* * * *

If this case had arisen in any Circuit (other than the Sixth) in which the scope of EMTALA has previously been decided, the outcome would have been exactly the same as the decision below. That is, the hospital would have been awarded summary judgment and the patient would have been left to assert whatever state law malpractice claim she has. Of course, the reasoning of the other courts would have been markedly different. Those courts would have held that the undisputed lack of actual knowledge by the hospital and its physicians of any emergency medical condition at the time of transfer and the undisputed provi-

---

[13] The district court's finding that there was a genuine issue of material fact as to whether Ms. Johnson was stabilized at the time of her transfer to Crestview was based on conflicting testimony concerning the effects of the new infection that she acquired the day before the transfer. See Pet. App. A29-A36. Under the test articulated in *Bryan* and *Collins*, however, that finding is irrelevant because EMTALA did not apply to the treatment and transfer decisions made by Ms. Johnson's physicians at that time. *See supra*, n.11.

sion of treatment to stabilize the emergency medical condition for which Ms. Johnson was initially admitted to the hospital required dismissal of Ms. Johnson's claims under EMTALA.

The Sixth Circuit reached the same ultimate judgment, but by a path that cannot be located within the language of the statute. Respondent urges the Court to do more than simply inform the court of appeals of the error of its way, and instead, take advantage of this case as an opportunity to make clear that EMTALA is not a radical statute that effectively supersedes state malpractice law for all patients who arrive at a hospital's emergency room.

The Court should hold that EMTALA fills the gap in state law by creating a physician-patient relationship that imposes upon hospitals limited duties to respond to the known needs of a patient's immediate emergency condition and then looks to state law exclusively to govern the physician-patient relationship thereafter. By taking this approach, the Court will accomplish much more than merely eliminating an aberrational rule of law that applies only in four States, which is what petitioner urges the Court to do. Instead, the Court can provide critical guidance that will spare both hospitals (and physicians) and patients the need to expend scarce resources litigating the metes and bounds of EMTALA and spare federal courts the burden they now assume of being inundated with routine medical malpractice cases masquerading as federal statutory causes of action.

The argument of the United States as *amicus curiae* nudges the Court to go beyond the limited objectives of petitioner. Respondent thus urges the Court to recognize the provocative nature of the government's submission and to reject it by entertaining and adopting respondent's alternative theories in support of the judgment below.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

BRYAN TODD THOMPSON
THOMAS S. CALDER
MILLICENT A. TANNER
DINSMORE & SHOHL LLP
2000 Meidinger Tower
Louisville, KY 40202
(502) 585-2450

CARTER G. PHILLIPS *
JACQUELINE GERSON COOPER
SIDLEY & AUSTIN
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 736-8000

Counsel for Respondent

*Counsel of Record

September 22, 1998

(10)

No. 97-53

FILED
OCT 20 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The

Supreme Court of the United States

October Term, 1998

JANE M. ROBERTS, Guardian for Wanda Y. Johnson,

Petitioner,

vs.

GALEN OF VIRGINIA, INC., Formerly d/b/a Humana Hospital – University of Louisville,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

REPLY BRIEF OF PETITIONER

JOSEPH H. MATTINGLY III
104 West Main Street
P.O. Box 678
Lebanon, Kentucky 40033
Telephone: (502) 692-1718

Counsel of Record for Petitioner

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

20 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTRODUCTION 1

ARGUMENT 2

I. THE COURT SHOULD NOT CONSIDER THE ALTERNATIVE GROUNDS FOR AFFIRMANCE URGED BY THE RESPONDENT BECAUSE NEITHER WAS PROPERLY PRESERVED FOR REVIEW 2

II. THE INTERPRETATION OF EMTALA PROPOSED BY THE UNITED STATES DOES NOT CREATE A FEDERAL STANDARD OF CARE FOR MEDICAL DIAGNOSIS AND TREATMENT FOR PATIENTS WHO ENTER HOSPITAL EMERGENCY ROOMS AND SHOULD BE ADOPTED 10

CONCLUSION 16

TABLE OF AUTHORITIES

Page

CASES

California Federal Sav. & Loan Ass'n v. Guerra, 479 U.S. 272 (1987) 13

Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990) 6

De Sylva v. Ballentine, 351 U.S. 570 (1956) 13

Eberhardt v. City of Los Angeles, 62 F.3d 1253 (9th Cir. 1995) 6

Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991) 6

Holcomb v. Monahan, 30 F.3d 116 (11th Cir. 1994) 6

Marshall v. East Carroll Parish Hosp., 134 F.3d 319 (5th Cir. 1998) 5

Reconstruction Finance Corp. v. Beaver County, Pa., 328 U.S. 204 (1946) 14

Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132 (8th Cir. 1996) 6

Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990) 4, 9

United States v. Kimbell Foods, Inc., 440 U.S. 715 (1979) 13

Urban by and through Urban v. King, 43 F.3d 523 (10th Cir. 1994) 6

Vickers v. Nash General Hosp., Inc., 78 F.3d 139 (4th Cir. 1996) 4, 6

TABLE OF AUTHORITIES – Continued

Page

STATUTES

Emergency Medical Treatment and Labor Act

42 U.S.C. § 1395dd, *et seq.* 1

42 U.S.C. § 1395dd(a) 5, 14

42 U.S.C. § 1395dd(b) 7, 15

42 U.S.C. § 1395dd(c) 15

42 U.S.C. § 1395dd(d)(3) 15

42 U.S.C. § 1395dd(d)(3)(A) 14

42 U.S.C. § 1395dd(e)(1) 7

42 U.S.C. § 1395dd(e)(3)(A) 7

42 U.S.C. § 1395dd(e)(3)(B) 7

42 U.S.C. § 1395dd(f) 12

Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, Tit. IV, § 4027 (a)(1)(A), 104 Stat. 1399-117 15

RULES

Sup. Ct. R. 15.2 10

INTRODUCTION

After five years of litigation and the consumption of untold judicial resources, the Respondent disavows the single rationale invoked by the lower courts in dismissing Petitioner's case and abandons the position it championed throughout these proceedings in a style analogous to its abandonment and disavowal of the Petitioner herself which gave rise to this suit.

The Respondent concedes the only issue upon which the Court granted certiorari. Therefore, this matter is ripe for reversal and remand for trial on the merits of the Petitioner's claims. Undeterred, the Respondent implores the Court to entertain additional grounds for affirming the lower court's summary judgment and it urges the Court not to embrace the interpretation of the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), proposed by the United States in its amicus brief for fear of "extraordinary" interference by the federal government with the practice of medicine in the hospital setting.[1]

While it is impossible to adequately address the merits of the Respondent's alternative grounds for affirmance and also respond to its articulated fear of the "federalization" of medical malpractice law within the page limitations of a Reply Brief, the Petitioner will point out why those alternative grounds are inappropriate for

---

[1] The Respondent fails to acknowledge that its own decision to tap public funds by electing to participate in the Medicare program and to accept millions of additional public dollars from state and local governments justifies accountability to the public and those governmental agencies.

this Court's consideration. Furthermore, the Petitioner will address the Respondent's unwarranted concerns about the interpretation of EMTALA proposed by the United States.

ARGUMENT

I. THE COURT SHOULD NOT CONSIDER THE ALTERNATIVE GROUNDS FOR AFFIRMANCE URGED BY THE RESPONDENT BECAUSE NEITHER WAS PROPERLY PRESERVED FOR REVIEW.

After acknowledging that the lower courts erred in the sole rationale utilized to dismiss Petitioner's claim by summary judgment, the Respondent proposes that summary judgment nonetheless be affirmed because (a) it had no duty to stabilize Wanda Johnson since her treating physicians did not have actual knowledge that she was suffering from an emergency medical condition at the time they ordered her discharge and, (b) EMTALA does not apply to treatment and transfer decisions made after a patient's initial emergency room screening and stabilizing treatment and admission into the hospital. These alternative arguments go to the threshold issue of the applicability of EMTALA, not the issue considered by the Sixth Circuit in this case, i.e., the appropriate standard of proof of EMTALA violations where applicability has been established. Although the Respondent claims otherwise,

it is clear that neither of these issues is ripe for consideration by this Court.[2]

The Respondent devoted approximately one page of its 26-page initial memorandum in the trial court to an argument that it was entitled to dismissal because EMTALA was inapplicable to Wanda Johnson's transfer where her treating physicians did not perceive that she suffered from an emergency medical condition at that time. The trial court, although not expressly considering this argument, overruled the Respondent's motion for partial summary judgment. The Respondent then abandoned this argument, not citing this ground for dismissal in either the motion for reconsideration to the trial court which resulted in the entry of summary judgment or at any time before the Court of Appeals for the Sixth Circuit. The Respondent now claims that it made reference to this long abandoned argument in its Sixth Circuit brief. However, the passage quoted from that brief was not part

---

[2] The Respondent's grounds for proposing that the Court extend jurisdiction and decide its two new issues is truly unique. It acknowledges that neither was "addressed" below but contends that "it is plain that, if the Sixth Circuit had rejected either of the alternative theories, then such a decision would warrant review by this Court for essentially the same reason this case was appropriate for review – a split in the circuit courts of appeals on a recurring legal issue of federal law." (Respondent's Brief at 33). However, it is not at all "plain" that a rejection by the Sixth Circuit of these arguments would have created a split among the circuit courts of appeals. Furthermore, where, as here, the issues have not been fully briefed or argued below, the "interest in efficient judicial administration" would not be furthered by entertainment of these alternative grounds.

of an argument that Johnson's treating physicians were unaware of an *emergency medical condition* on the date of Johnson's transfer, but, instead, was part of the Respondent's attempt to explain the holding in *Vickers v. Nash General Hosp, Inc.*, 78 F.3d 139 (4th Cir. 1996), and the Respondent's contention that Johnson's treating physicians were unaware that Johnson's condition was *not stable* upon transfer.

This claim for dismissal, briefly mentioned in the trial court and then abandoned, was undoubtedly rejected when the lower court initially overruled the Respondent's motion for summary judgment because it ignores the distinction between the separate duties imposed by EMTALA upon hospitals to provide an appropriate medical screening *and* to stabilize patients who present with an emergency medical condition. The Respondent concedes that Johnson arrived at its hospital emergency room with an emergency medical condition. The existence of Johnson's emergency medical condition, as revealed by the Respondent's medical screening examination, triggered the hospital's second duty under EMTALA – to provide stabilizing treatment and to refrain from transferring her elsewhere unless her condition was stabilized at the time of transfer. *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990).

The Respondent apparently contends that in addition to its initial medical screening examination which revealed an emergency medical condition, it conducted subsequent medical screening examinations, including a medical screening examination on the day of Johnson's transfer. Presumably, that final medical screening examination revealed no emergency medical condition. The fallacy of Respondent's argument lies in the notion that

hospitals can conduct *multiple* screening examinations and that the outcome of each examination then determines its concomitant duty to the patient under EMTALA. EMTALA clearly contemplates that a single medical screening examination take place at a hospital's emergency room upon the patient's initial presentation to the facility. 42 U.S.C. § 1395dd(a). The statute provides that if this initial medical screening examination does not reveal an emergency medical condition, no further EMTALA duties are triggered. Where, as in Johnson's case, the hospital conducted its initial medical screening examination and determined that an emergency medical condition existed, its duty under EMTALA is to provide stabilizing treatment and to ensure that the patient is still in a stabilized condition prior to any transfer. The Respondent cannot successfully argue here that it "screened" Johnson each day and determined, although incorrectly, that no emergency medical condition existed at the final such "screening." In fact, there is ***no evidence*** that such a "pre-transfer" screening was actually performed in this case.

The cases cited by the Respondent are easily distinguishable. None deal with the situation that is present in this case, i.e., where the hospital's initial medical screening examination actually revealed an emergency medical condition. In each of the cases cited by the Respondent, the hospital's medical screening examination in the emergency room failed to reveal an emergency medical condition and therefore did not trigger the additional stabilization duties imposed by EMTALA.[3]

---

[3] See *Marshall v. East Carroll Parish Hosp.*, 134 F.3d 319 (5th Cir. 1998) (Hospital physician failed to diagnose cerebro-

Even if the Respondent's interpretation of EMTALA were correct, it would not be entitled to summary judgment. The Respondent cites the affidavits of its doctors for the proposition that those doctors perceived no emergency medical condition on the date of Johnson's transfer. However, the cited affidavits do not address the specific

---

vascular accident, believed patient had only respiratory infection and discharged her from emergency room); *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996) (Hospital emergency room failed to diagnose skull fracture and discharged patient who died four days later); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) (Hospital believed patient was suffering from muscle spasms, not emergency medical condition, upon presentation to hospital emergency room, was not admitted to the hospital and discharged with instructions to see a doctor the next day); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) (Emergency room doctors diagnosed heroin overdose and permitted patient to walk out of hospital. Patient was shot by police 30 hours later in a crazed state); *Urban by and through Urban v. King*, 43 F.3d 523 (10th Cir. 1994) (Hospital emergency room staff failed to diagnose fetal stress and instructed patient to return for repeat stress test the following morning); *Holcomb v. Monahan*, 30 F.3d 116 (11th Cir. 1994) (Plaintiff failed to provide evidence that patient had emergency medical condition when discharged from emergency room); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) (Patient discharged from emergency room after doctors diagnosed musculoskeletal pain. The next morning, the patient died of a heart attack); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) (Patient discharged four hours after his arrival to the emergency room diagnosed with influenza. The patient died later that same day after experiencing cardiopulminary arrest).

issue of whether Johnson had an emergency medical condition prior to her transfer. Rather, those affidavits contend that Johnson's emergency medical condition had been stabilized.[4] Dr. Frank Miller was the only physician who specifically addressed the issue of whether Johnson had an emergency medical condition on the date of her transfer. However, Dr. Miller admitted that he was on vacation at the time Johnson was transferred and neither examined Johnson nor was even at the hospital on or near that date. (Deposition of Frank Miller, M.D., R. 53, at 9-10). His opinion was based entirely upon a review of Johnson's medical records.

Dr. John Stuy, Johnson's treating physician in Indianapolis, also reviewed Johnson's medical records for the last days of her hospitalization at the Respondent's hospital. His deposition testimony can easily be read to express an opinion, contrary to that of Dr. Miller's, that on the date of her transfer Johnson had an emergency medical condition which any reasonably competent practitioner would have recognized. (J.A. at 62-70). This opinion is buttressed by the deposition testimony of hospital employees[5] who explained that on the evening before her discharge, Johnson's right lung had collapsed, and that

---

[4] The statutory definitions of "emergency medical condition", "stabilized" and "to stabilize" have very different definitions. *Compare* 42 U.S.C. § 1395dd(e)(1) with 42 U.S.C. § 1395dd(e)(3)(A) and 42 U.S.C. § 1395dd(e)(3)(B).

[5] 42 U.S.C. § 1395dd(b) imposes stabilization duties and transfer restrictions when a "hospital" determines that the individual has an emergency medical condition. The Respondent's argument incorrectly imposes those duties only when a "physician" makes such a determination.

on the morning of her transfer, Johnson's white blood count was over twice the normal level, her temperature had been rising for two days and the presence of infection was indicated by her cloudy urine, thick yellow sputum and an elevated heart rate. (Deposition of Donna Kaelin, R. 48 at 16; Deposition of Karen Martin, R. 9 at 14-19; Deposition of Suzanne Griffith, R. 49 at 9-10). Construing the evidence and all reasonable inferences in the light most favorable to the Petitioner, Respondent clearly is not entitled to summary judgment on this surprise new ground.

The Respondent's second alternative argument for affirmance is even less appropriate for serious consideration. Respondent admits to having an EMTALA-imposed duty to stabilize patients like Johnson, but asserts that such duty only applies in emergency room settings and ceases after the patients are admitted to the hospital.[6] In short, it contends that EMTALA applies only to emergency rooms. Respondent's contention to the

---

[6] In making this argument, the Respondent takes unwarranted liberty with its characterization of the Petitioner's contention in this case. Respondent's assertion that the Petitioner "has never disputed that Mrs. Johnson's initial injuries were stabilized during her two-month hospital stay," is simply not true. It has been the Petitioner's claim that Wanda Johnson's condition was volatile during her entire hospitalization. The urinary tract infection, collapsed lung, signs of pneumonia and elevated temperature experienced by Johnson during the final days of her hospitalization in Louisville were not "new" conditions never before experienced by Johnson. Rather, they were recurrent problems associated with Johnson's emergency medical condition which the Respondent had been unable to "stabilize."

contrary, this argument was *never* asserted in the courts below. The snippets quoted by the Respondent from its lower court briefs to the effect that "EMTALA applies first and foremost to a patient who comes to a hospital seeking treatment for an emergency medical condition" is far short of this entirely new and novel argument that a hospital's obligations cease once a patient moves from the emergency room to a hospital room.

In fact, the Respondent's new argument is directly at odds with the precedent established by the Court of Appeals for the Sixth Circuit in *Thornton* where the court rejected the notion that a hospital's stabilization duties under EMTALA were extinguished when the patient was transferred from a hospital emergency room to the hospital's intensive care unit for ten days and then to the hospital's regular in-patient care for eleven days before being discharged. The court explained:

> [a]lthough emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. . . . Emergency care must be given until the patient's emergency medical condition is stabilized.

895 F.2d at 1135.

The courts below expressed no views on the issues now raised by the Respondent and neither issue was argued or resolved. In fact, the lower courts had moved beyond the threshold applicability arguments now presented by the Respondent to consider the standard of proof for EMTALA violations where the Act had been determined to be applicable to Wanda Johnson's case.

Finally, the Respondent failed to identify either of these issues as bearing upon the matter before the Court if certiorari was granted in its brief in opposition to the petition for writ of certiorari as required by Sup. Ct. R. 15.2. Scarce judicial resources have been committed to deciding the merits of the question presented in the petition and new and novel issues presented at this time by the Respondent should be deemed by the Court to have been waived.[7]

II. THE INTERPRETATION OF EMTALA PROPOSED BY THE UNITED STATES DOES NOT CREATE A FEDERAL STANDARD OF CARE FOR MEDICAL DIAGNOSIS AND TREATMENT FOR PATIENTS WHO ENTER HOSPITAL EMERGENCY ROOMS AND SHOULD BE ADOPTED.

As pointed out by the Respondent, this is the first case the Court has agreed to review arising under

[7] To permit the Respondent to now introduce supplemental issues for consideration would both deprive the lower courts of the benefit of first considering those issues and deny the parties the opportunity to properly prepare a record thereon. In addition, it would frustrate the amicus curiae process. By granting a writ of certiorari on a specific issue, potential interested parties have notice and an opportunity to provide the Court with helpful perspectives to assist in the decision-making process. It is apparent from the number of groups who have participated as amici in this case that interpretation of EMTALA has important implications to many people and organizations in this country. If the Respondent is permitted to change the issue, the Court will not have the benefit of the perspectives of these interested persons and groups on these issues first raised by Respondent after submission of the amici briefs.

EMTALA. Though the Respondent concedes that, contrary to the Sixth Circuit's holding, the nature of proof required of a claimant to establish a violation under EMTALA has nothing to do with the motivations of hospitals, staff and physicians, the related and "fairly included" question of the *appropriate* standard of proof remains at issue. Both the Respondent and the United States urge the Court to define the standard of proof required of a claimant where EMTALA is applicable. The Petitioner urges the Court to adopt the position espoused by the United States because it is wholly consistent with EMTALA's purpose – namely, to deter patient dumping and to compensate victims of dumping. Nothing in EMTALA threatens to "federalize" medical malpractice law as claimed by the Respondent.

In defining the appropriate standard of proof under EMTALA we must begin one step beyond the question of the Act's applicability and Respondent's overheated rhetoric that the government's reading would transform EMTALA into a "litigation-creating machine."[8] Assuming a case, such as the one before the Court, where the claimant has established that EMTALA applies, the inquiry becomes the nature of proof required to show a violation.

EMTALA seeks to insure that all Americans not only have *access* to emergency treatment at Medicare participating hospitals, but also receive therefrom such treatment as is necessary to stabilize their condition at least at

[8] Indeed, the lower courts determined that EMTALA was applicable to this case but determined that the Petitioner had failed to establish violation of the Act under their heightened and erroneous "improper motive" standard.

the minimum level of quality required by the medical profession's own established norms. Hospitals are required to provide stabilizing treatment based upon objective "reasonableness" standards. In other words, a hospital's "negligent" violation of EMTALA is actionable. EMTALA's key definitions focus on the reasonableness of a hospital's determinations of medical probabilities and medical benefits under the circumstances prevailing at the time of treatment. If a hospital makes a determination that a patient has been stabilized, the hospital is liable only if it made the determination unreasonably, i.e., negligently. Of course, these standards are familiar to the Respondent and to other hospitals because they are the same standards used under state tort law.

Contrary to the Respondent's claim, this reasonableness or negligence standard neither preempts state medical malpractice laws nor establishes a federal standard of emergency care. In fact, Congress explicitly disclaimed any intent to preempt state law or to "occupy the field" of medical malpractice law. Instead, EMTALA provides that, "the provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with the requirements of this section." 42 U.S.C. § 1395dd(f).

Far from field preemption, Congress merely intended in EMTALA to provide for conflict preemption. Nothing in EMTALA prevents states from simultaneously regulating the same conduct by state medical malpractice or other laws.[9] It is well established that conflict preemption

---

[9] As pointed out by Petitioner's amici, no fewer than twenty-two states had already passed laws governing the provision of emergency services when EMTALA was enacted. (Brief of Amici Curiae, NOW Legal Defense and Education Fund and others, in support of Petitioner, at 11 n. 5).

does not forbid double regulation, it only preempts those state laws where compliance with both federal and state regulations is a physical impossibility or which pose "as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." See, e.g., *California Federal Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272 (1987) (discussing the preemptive effect of Title VII). Under this preemption standard, it is apparent that existing medical malpractice laws are preserved and that state laws which punish the same conduct as EMTALA, whether malpractice torts or otherwise, are perfectly appropriate.

As urged by the United States, rather than establishing a federal standard of emergency room care, EMTALA simply borrows well-developed state-law standards of medical reasonableness to assess conduct. This interpretation is consistent with this Court's prior holdings that even though the scope of a federal right is a federal question, its content may be determined by state, rather than federal law, particularly where there is no federal body of law and the courts can draw on the ready-made body of state law addressed to the subject. See *United States v. Kimbell Foods, Inc.*, 440 U.S. 715 (1979) (incorporating state law to determine priority between state and federal liens); *De Sylva v. Ballentine*, 351 U.S. 570 (1956) (deciding that state law determines whether a child is a "child" for the purpose of taking statutory copyright renewal rights, to avoid upsetting settled expectations under state intestacy and family laws);

Reconstruction Finance Corp. v. Beaver County, Pa., 328 U.S. 204 (1946) (upholding a state tax applied to Reconstruction Finance Corporation property). Indeed, this reading is fortified by Section (d)(3)(A) of EMTALA which provides that personal injury damages against a hospital under the Act are assessed "under the law of the State in which the hospital is located." 42 U.S.C. § 1395dd(d)(3)(A). This reading therefore does not violate principles of federalism. On the other hand, if the Respondent is correct that EMTALA is simply a "gap-filler" and serves only the purpose of creating a duty to enter into a physician-patient relationship in the hospital setting and then gives way to state medical malpractice laws, Congress would have stopped after enacting the medical screening requirements of 42 U.S.C. § 1395dd(a).[10] At the point when the medical screening examination is provided, a physician-patient relationship has been formed and state medical malpractice laws are triggered. Instead, after Congress accomplished the objective of forcing a physician-patient relationship it proceeded to address the manner in which Medicare

---

[10] If the Respondent's reading is correct, it stands to escape liability under both state and federal law. The Sixth Circuit determined that the independent contractor surgical resident from the University of Louisville Medical School who authorized Wanda Johnson's discharge was not the ostensible agent of the Respondent's hospital and that therefore, the Respondent was not liable under state medical malpractice law if the surgical resident's discharge decision was negligent. J.A. at A16-A23. In light of this ruling, the Respondent can be accountable to Wanda Johnson for the surgical resident's negligence only under EMTALA because it imposes direct rather than vicarious liability upon hospitals.

hospitals are required to treat their patients in 42 U.S.C. § 1395dd(b) and (c).

Perhaps the clearest expression of Congress's intent that hospitals' conduct be governed by existing standards of medical reasonableness was its 1990 OBRA amendments providing that, "[i]n considering allegations of violations of [EMTALA] and imposing [civil penalties]", the secretary shall "request the appropriate utilization and quality control peer review organization [PRO] . . . to assess whether the individual involved had an emergency medical condition which had not been stabilized." OBRA 1990, § 4027(a)(1)(A), 104 Stat. 1399-117, codified at 42 U.S.C. § 1395dd(d)(3). As pointed out by the United States, Congress's decision to require use of the PRO mechanism in civil penalty actions under EMTALA fully supports the conclusion that Congress understood that EMTALA liability is premised on adherence to recognized medical standards of care.

Although the Respondent urges the Court to reject the standard of proof proposed by the United States, it offers no alternative standard for consideration. Instead, it pleads with the Court to reach a decision, any decision, that would limit EMTALA's scope and applicability and make it more difficult for claimants to prove violations. It would have this Court believe that the United States seeks to federalize medical malpractice law in the hospital setting and to inject itself into the medical decision making process throughout the country. This is simply not the argument pressed by the United States and the Respondent's attempts to mischaracterize that argument should be rejected. Instead, the Court should adopt the position of the United States that Congress intended to

hold hospitals accountable for their negligent violation of EMTALA.

CONCLUSION

The judgment of the Court of Appeals for the Sixth Circuit should be reversed. This case should be remanded to the United States District Court for the Western District of Kentucky for a trial on the merits of the Petitioner's claim that the Respondent violated EMTALA.

Respectfully submitted on
October 20, 1998,

JOSEPH H. MATTINGLY III
Counsel of Record for the Petitioner

JOSEPH H. MATTINGLY III, P.S.C.
Attorneys at Law
P.O. Box 678
104 West Main Street
Lebanon, Kentucky 40033
(502) 692-1718

FILED
JUL 23 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 97-53

In the Supreme Court of the United States

OCTOBER TERM, 1997

JANE M. ROBERTS, GUARDIAN FOR WANDA Y. JOHNSON, PETITIONER

v.

GALEN OF VIRGINIA, INC., FORMERLY DBA HUMANA HOSPITAL—UNIVERSITY OF LOUISVILLE, DBA LOUISVILLE HOSPITAL

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

SETH P. WAXMAN
Solicitor General
Counsel of Record

FRANK W. HUNGER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
Assistant to the Solicitor General

BARBARA C. BIDDLE
CARL E. GOLDFARB
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

35 pp

QUESTION PRESENTED

Whether a claim brought under the private cause of action provision of the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd(d), requires proof of an improper motive as a prerequisite for recovery.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement	2
Summary of argument	9
Argument:	
A violation of 42 U.S.C. 1395dd(b) occurs when a covered entity fails to stabilize a patient before transfer, regardless of the motive with which the entity acted	11
A. The text of EMTALA makes clear that establishing a violation does not require proof of motive	11
B. The legislative history of EMTALA supports the conclusion that a hospital's obligations under Section 1395dd(b) do not turn on the motive with which the hospital acts	18
C. The Secretary of Health and Human Services has taken the position that "improper motive" is not an element of an EMTALA violation	23
D. There is nothing in the "appropriate medical screening examination" provision of EMTALA, 42 U.S.C. 1395dd(a), that supports an improper motive requirement in Section 1395dd(b)	24
Conclusion	29

TABLE OF AUTHORITIES

Cases:

American Nat'l Red Cross v. *S.G.*, 505 U.S. 247 (1992)	18
Board of Educ. of the Hendrick Hudson Cent. Sch. Dist. v. *Rowley*, 458 U.S. 176 (1982)	25
Burditt v. *HHS*, 934 F.2d 1362 (5th Cir. 1991)	23

Cases—Continued: Page

Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) 23
Cleland v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) 6, 7, 10, 24
Correa v. *Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996) 2, 26
Eberhardt v. *City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) 26
Gatewood v. *Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) 20, 25
Holcomb v. *Monahan*, 30 F.3d 116 (11th Cir. 1994) 26
Inter-Modal Rail Employees Ass'n v. *Atchison, T. & S.F. Ry.*, 117 S. Ct. 1513 (1997) 12
Martin v. *OSHRC*, 499 U.S. 144 (1991) 23
Oncale v. *Sundowner Offshore Servs., Inc.*, 118 S. Ct. 998 (1998) 19
Power v. *Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994) 25
Repp v. *Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994) 26
Summers v. *Baptist Med. Cent. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) 25
United States v. *Gonzales*, 117 S. Ct. 1032 (1997) 11
United States v. *Wiltberger*, 18 U.S. (5 Wheat.) 76 (1820) 11-12
Vargas v. *Del Puerto Hosp.*, 98 F.3d 1202 (9th Cir. 1996) 18
Vickers v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996) 26
Walters v. *Metropolitan Educ. Enters.*, 117 S. Ct. 660 (1997) 16

Statutes and regulations: Page

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Tit. IX, § 9121(b), 100 Stat. 164 19
Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd *et seq.* 1, 6, 8
42 U.S.C. 1395dd(a) 2, 8, 14, 24, 25, 27, 28, 29
42 U.S.C. 1395dd(b) ..... *passim*
42 U.S.C. 1395dd(b)(1)(A) 3, 9, 14
42 U.S.C. 1395dd(c) 3, 4, 5, 12
42 U.S.C. 1395dd(c)(1)(A)(ii) 16
42 U.S.C. 1395dd(c)(2) 4
42 U.S.C. 1395dd(d)(1) 1
42 U.S.C. 1395dd(d)(1) (1988) 16
42 U.S.C. 1395dd(d)(1)(A) 4
42 U.S.C. 1395dd(d)(1)(B) 4
42 U.S.C. 1395dd(d)(2) 1
42 U.S.C. 1395dd(d)(2) (1988) 17
42 U.S.C. 1395dd(d)(2)(A) 4, 18
42 U.S.C. 1395dd(d)(2)(B) 4, 18
42 U.S.C. 1395dd(d)(3) 17
42 U.S.C. 1395dd(e)(1)(A) 3, 9, 15
42 U.S.C. 1395dd(e)(1)(B) 3, 15
42 U.S.C. 1395dd(e)(2) 2
42 U.S.C. 1395dd(e)(3)(A) 3, 9, 13, 29
42 U.S.C. 1395dd(e)(3)(B) 3, 13
42 U.S.C. 1395dd(e)(4) 3
Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4009(a), 101 Stat. 1330-56 22
101 Stat. 1330-57 22
Omnibus Budget Reconcilation Act of 1989, Pub. L. No. 101-239, Tit. VI, § 6211(a), 103 Stat. 2245 22
Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, Tit. IV, 104 Stat.:
Tit. IV, § 4008(b)(1), 104 Stat. 1388-44 17
§ 4008(b)(3)(A), 104 Stat. 1388-44 17
§ 4008(b)(3)(B), 104 Stat. 1388-44 17
§ 4027(a)(1)(A), 104 Stat. 1399-117 17
42 U.S.C. 1320a-7a 4
42 U.S.C. 1320c-5(a)(1) 18

Statutes and regulations—Continued:	Page
42 U.S.C. 1395f(c)	2
42 U.S.C. 1395y(a)(3)	2
42 U.S.C. 1395bb	14
42 U.S.C. 1395cc(a)(1)	17
42 U.S.C. 1395cc(a)(1)(I)	2, 17
42 U.S.C. 1395cc(b)(2)	2, 4, 17
42 U.S.C. 1395cc(b)(2)(A)	17
42 U.S.C. 1395qq	2
42 C.F.R. 489.24	2, 3, 14
42 C.F.R. 489.24(g)(2)(v)	17
Miscellaneous:	
131 Cong. Rec. (1985):	
p. 19,833	21
p. 28,568	22
p. 28,569	22
p. 29,829	21
p. 29,835	21
59 Fed. Reg. 32,086 (1994)	23, 27
H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. (1985)	21
H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. (1987)	22
H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. (1989)	22
H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1 (1985)	2, 19
H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3 (1985)	2, 19
The Random House Dictionary of the English Language (2d ed. 1987)	25
Department of Health and Human Services, *State Operations Manual Provider Certification* (1998)	27
Webster's Third New International Dictionary (1976)	25

In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-53

JANE M. ROBERTS, GUARDIAN FOR WANDA Y. JOHNSON, PETITIONER

v.

GALEN OF VIRGINIA, INC., FORMERLY DBA HUMANA HOSPITAL—UNIVERSITY OF LOUISVILLE, DBA LOUISVILLE HOSPITAL

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

This case concerns the requirements for establishing liability under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd *et seq*. EMTALA requires hospitals with Medicare provider agreements, as a condition of eligibility, to provide all individuals who come to the hospital with essential emergency care. Similar requirements are imposed on physicians working at those hospitals. The United States plays an important role in the enforcement of EMTALA's requirements. Although private entities may bring an action under 42 U.S.C. 1395dd(d)(2) for damages and injunctive relief, the Secretary of Health and Human Services is responsible for enforcing the statutory requirements through civil

money penalties and through exclusion from participation in the Medicare and Medicaid programs. 42 U.S.C. 1395dd(d)(1); see also 42 U.S.C. 1395cc(b)(2); 42 C.F.R. 489.24. At the Court's invitation, the United States filed a brief as amicus curiae at the petition stage of this case.

STATEMENT

1. EMTALA was enacted in 1986 in an effort to ensure that individuals who needed emergency treatment were not turned away at the hospital door or transferred prematurely. H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 27 (1985); H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, at 5 (1985). The Act, in 42 U.S.C. 1395dd(a) and (b), imposes two principal obligations on hospitals that have entered into Medicare provider agreements with the Secretary of Health and Human Services. 42 U.S.C. 1395dd(e)(2).[1]

First, when an individual comes to a covered hospital and a request is made on the individual's behalf for examination or treatment for a medical condition, the Act requires the hospital to provide "an appropriate medical screening examination within the capability of the hospital's emergency department * * * to determine whether or not an emergency medical condition * * * exists." 42 U.S.C. 1395dd(a). The Act does not define the term "appropriate medical screening examination." The term "emergency medical condition" is defined as a condition "manifesting itself by acute symptoms of sufficient severity * * * that the absence of immediate medical

[1] The statutory scheme governing the Medicare program requires participating hospitals to comply with the requirements of EMTALA. 42 U.S.C. 1395cc(a)(1)(I). Almost all non-federal hospitals have Medicare provider agreements. See *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1191 (1st Cir. 1995) ("ninety-nine percent of American hospitals [are] covered by EMTALA"), cert. denied, 517 U.S. 1136 (1996). With the exception of hospitals managed by the Indian Health Service, federally run hospitals are ineligible to enter into Medicare provider agreements. 42 U.S.C. 1395f(c); 1395qq; 1395y(a)(3).

attention could reasonably be expected to result in * * * serious jeopardy [to the health of the individual or her unborn child], * * * serious impairment to bodily functions, or * * * serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1)(A). A separate definition of "emergency medical condition" covers a pregnant woman who is having contractions. 42 U.S.C. 1395dd(e)(1)(B). See generally 42 C.F.R. 489.24.

Second, if the hospital determines that an individual who has come to the hospital is suffering from an emergency medical condition, the hospital must either, "within the staff and facilities available at the hospital," provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or transfer the patient to another hospital in accordance with the provisions of subsection (c) of the Act. 42 U.S.C. 1395dd(b)(1)(A); see generally 42 C.F.R. 489.24.[2] The term "to stabilize" means "to provide such medical treatment of the [emergency medical] condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual." 42 U.S.C. 1395dd(e)(3)(A). The term "stabilized" is defined accordingly. 42 U.S.C. 1395dd(e)(3)(B).

Subsection (c) states that "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized * * *, the hospital may not transfer the individual unless" the individual (or a legal representative) makes an informed, written request to be transferred; a physician has signed a certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or her unborn child; or, if a physician is not available, a qualified

[2] The Act defines "transfer" to include "discharge" of the individual. 42 U.S.C. 1395dd(e)(4).

medical person, in consultation with a physician, has made the required risk/benefit determination. 42 U.S.C. 1395dd(c). Subsection (c) further provides that in order for such a transfer to be appropriate, any receiving hospital must agree to accept the transfer of the individual and to provide appropriate medical treatment, and the sending hospital must forward all relevant medical records. 42 U.S.C. 1395dd(c)(2).

A participating hospital that negligently violates a requirement of the Act is subject to a civil money penalty of not more than $50,000 for each such violation. 42 U.S.C. 1395dd(d)(1)(A). Certain physicians who negligently violate a requirement of the Act with regard to an individual in a participating hospital are similarly subject to a civil money penalty of not more than $50,000 for each such violation. 42 U.S.C. 1395dd(d)(1)(B). If the violation is "gross and flagrant or is repeated," the physician is also subject to exclusion from participation in Medicare and federally funded state health care programs. *Ibid.* See also 42 U.S.C. 1395cc(b)(2): Civil money penalties and exclusions are imposed by the Secretary of Health and Human Services, pursuant to 42 U.S.C. 1320a-7a, as incorporated into 42 U.S.C. 1395dd(d)(1)(A) and (B).

The Act also provides for two private rights of action against participating hospitals, but not against physicians. The Act provides that "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [EMTALA]" may bring a civil action to obtain those damages that are available for personal injury under the law of the State in which the hospital is located, as well as for appropriate equitable relief against the hospital. 42 U.S.C. 1395dd(d)(2)(A). The Act further provides that "[a]ny medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of [EMTALA]" may bring a civil action for similar damages and appropriate equitable relief. 42 U.S.C. 1395dd(d)(2)(B).

2. Wanda Y. Johnson was injured in May 1992 when she was struck by a vehicle while walking. Her injuries were life-threatening, and she was taken to the respondent hospital in Louisville, Kentucky, where she received treatment for the next two months. She suffered a series of infections and other complications, including pneumonia and urinary tract infections. Pet. App. A27.

In July 1992, respondent sought to transfer Johnson, who had no medical insurance, to a nursing home facility. At the time, she had symptoms of an active infection. She was placed on antibiotics and transferred on July 24, 1992, to Crestview Health Care Facility, a licensed nursing facility in Indiana, after two other nursing homes turned Johnson down following on-site evaluations of her condition by their directors of nursing. Pet. App. A2, A27. The day after she arrived at Crestview, Johnson's condition deteriorated and she was transported to Midwest Medical Center, an Indianapolis hospital. She remained at Midwest Medical Center for several months, incurring expenses in excess of $300,000. *Id.* at A27. The State of Indiana rejected Johnson's application for medical assistance under the Indiana Medicaid Program because Johnson failed to meet state residency requirements. *Id.* at A3.

3. On August 30, 1993, petitioner, as guardian for Johnson, filed suit in the United States District Court for the Western District of Kentucky, alleging, inter alia, that respondent had violated EMTALA by transferring Johnson to Crestview before the hospital had stabilized her condition. Petitioner, Johnson's aunt, did not allege that the initial screening that Johnson received was inappropriate, and respondent did not dispute that when Johnson arrived at the hospital she presented an emergency condition. Pet. App. A29. Nor did respondent claim to have complied with the provisions of 42 U.S.C. 1395dd(c) that permit the transfer of a patient whose emergency condition has not been stabilized. The case therefore

turned on whether Johnson had been properly stabilized under 42 U.S.C. 1395dd(b) before she was transferred.

The district court at first denied respondent's motion for summary judgment on the EMTALA claim. Pet. App. A45. The court concluded that there was a genuine issue of material fact as to whether Johnson was stabilized at the time of transfer. *Id.* at A36, A39. Citing the Sixth Circuit's decision in *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (1990), which the district court described as requiring "the presence of an improper motive as an essential element in a claim for relief under § 1395dd," the district court held that there was also a disputed issue of material fact as to whether the hospital acted with improper motive in transferring Johnson. Pet. App. A37.

The court based its ruling as to improper motive on evidence that a hospital social worker was facing considerable pressure to have Johnson discharged because the hospital was not being paid for her care. Pet. App. A37-A38.[3] Respondent moved for reconsideration, and in support of its motion, submitted affidavits from the physicians responsible for Johnson's discharge. The physicians all stated that Johnson was stable when transferred and that her financial condition did not influence their medical decision to authorize her transfer. *Id.* at A49-A50. The district court did not alter its previous conclusion that there was a material issue of fact regarding whether Johnson was stabilized at the time of transfer, but the court granted summary judgment to respondent because "the plaintiff presented no evidence that either the medical opinion that Johnson was stable or the decision to author-

[3] Joanna Nolte, a representative of Crestview Health Care Facility, testified that Nancy Fred, a social worker employed by respondent, explained to her that "they had been trying to discharge and with out any avail to other facilities and that she was getting a lot of pressure to discharge this person due to they knew they weren't going to get paid for this person." Pet. App. A14.

ize her transfer was caused by an improper motive[]." *Id.* at A50-A51.

4. The court of appeals affirmed the district court's judgment. Pet. App. A1-A25. The court of appeals stated that the district court "properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA." *Id.* at A10. The court noted that *Cleland* defined the term "appropriate medical screening" not to refer to malpractice or some other standard of care, but rather to refer "to the motives with which the hospital acts." *Id.* at A8-A9 (quoting *Cleland*, 917 F.2d at 272). The court further noted that the *Cleland* court concluded that a showing of improper motive is not limited to a refusal to treat patients because of indigence but also includes "prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (*e.g.*, AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition." *Id.* at A9-A10 (quoting *Cleland*, 917 F.2d at 272).

The court of appeals reasoned that a plaintiff must prove improper motive in order to distinguish an EMTALA claim from a state law claim for malpractice. The court explained:

> We reject the position espoused by [petitioner] that, to succeed on a claim under the EMTALA, she can prove that [respondent's] treatment of Johnson was not uniform to patients suffering the same medical condition as Johnson. Proof of disparate treatment, in [petitioner's] view, distinguishes an EMTALA claim from a state law negligence claim. If we were to adopt this position, however, we would effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable

> standard of care with respect to all similarly situated patients. In other words, we would require a hospital to prove that it has committed medical negligence or malpractice.

Pet. App. A11.

The court acknowledged that the issue in *Cleland* was whether the hospital had afforded the patient an "appropriate medical screening" in accordance with subsection (a) of 42 U.S.C. 1395dd, while the issue in the current case is whether the hospital failed to stabilize a patient with an emergency medical condition in violation of subsection (b) of that Section. Pet. App. A12 n.3. The court also noted that the term "appropriate medical screening," the linchpin of the court's analysis in *Cleland*, appears in subsection (a) but not in subsection (b). Nonetheless, explaining that it "s[aw] no rational reason to set forth differing standards when applying subsection[s] (a) and (b)," *ibid.*, the court of appeals concluded that *Cleland*'s improper motive requirement also applies in cases like this that arise under subsection (b).

As to the merits of the controversy before it, the court of appeals first noted that, under *Cleland*, physicians "are charged with the duty of stabilizing a patient's condition as it is known to them." Pet. App. A13. And the court further noted that respondent did not appeal the district court's holding that there was a genuine issue of material fact as to whether Johnson was stabilized when she was discharged by respondent. *Id.* at A14. The court nevertheless affirmed the district court's award of summary judgment for respondent, concluding that the district court correctly found that petitioner had failed to introduce evidence of improper motive that led to Johnson's discharge. *Id.* at A14-A16. Although the court acknowledged the evidence of the statement by the hospital social worker that she was facing pressure to discharge Johnson, the court emphasized that the social worker played no role in determining whether Johnson was in stable condition

before she was discharged, and that affidavits of the physicians who were involved stated that Johnson's financial status played no role in the discharge decision. See *ibid.*

Judge Nelson dissented in part. Pet. App. A23-A25. In his view, evidence that petitioner's treating physician relied on the hospital's social workers, together with evidence that the social workers were "receiving pressure from [respondent's] administration to get * * * Johnson discharged," *id.* at A25, was sufficient to raise "a genuine issue of fact as to whether [respondent] acted from an improper motive," *id.* at A24.

SUMMARY OF ARGUMENT

The text of EMTALA contains no suggestion that proof of improper motive is required to demonstrate that a hospital has failed, "within the staff and facilities available," to provide "such further medical examination and such treatment as may be required to stabilize the [patient's] medical condition." 42 U.S.C. 1395dd(b)(1)(A). That statutory language makes clear that the hospital's duty is to provide sufficient treatment "to stabilize the medical condition," without regard to the hospital's motive. Moreover, the statutory definition of "to stabilize" includes a requirement that the hospital assure "within reasonable medical probability" that the patient's condition is not likely to deteriorate during a transfer, and the definition of "emergency medical condition" refers to a condition that "could reasonably be expected to result in * * * serious jeopardy" to the patient's health. 42 U.S.C. 1395dd(e)(3)(A) and (e)(1)(A). Both of those "reasonableness" standards support the conclusion that EMTALA imposes an objective standard of care, and neither could be read to impose a further requirement that the hospital act with an improper subjective motive. Finally, EMTALA's sanctions provisions have from the beginning made clear that various sanctions may apply to a hospital that "negligently" violates the Act. Those provisions would be inexplicable if, as the Sixth Circuit held, violations of

EMTALA necessarily involve conduct that is more culpable than mere negligence because it was committed with an improper motive.

Although in enacting EMTALA Congress was concerned with "patient dumping"—refusing treatment to or transferring patients who could not pay for care—the legislative history confirms that Congress chose to address that problem through imposition of a substantive standard of medical care, not a prohibition against acting with an improper (non-medical) motive. Each of the relevant committee reports and statements in floor debates described the hospital's obligation under EMTALA in objective terms, and none suggested that proof of a violation depended on proof of improper motive. Finally, the Secretary of HHS has taken the position that improper motive is not an element of a violation of EMTALA. In light of the Secretary's enforcement responsibilities under EMTALA, that position is entitled to deference and, because it is reasonable, should be conclusive.

The Sixth Circuit attempted to justify its improper motive requirement on the ground that it had already held in *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (1990), that improper motive is an element of a violation of EMTALA's provision requiring hospitals to provide an "appropriate medical screening examination" to those who come to their emergency rooms. The "stabilization" provision at issue here, however, need not be construed to impose the same requirement as the "appropriate medical screening examination" provision, since neither the term the Sixth Circuit had found to be crucial in *Cleland*—"appropriate"—nor any similar term is present in the "stabilization" provision. Moreover, as both the Secretary and every other court of appeals to address the issue have concluded, the Sixth Circuit erred in holding that improper motive is an element even in an "appropriate medical screening examination" case. Every standard definition of the key word relied upon by the

Sixth Circuit—"appropriate"—makes clear that the word refers to the type of action, not the motive with which it is undertaken.

Finally, the policy concerns that drove the Sixth Circuit's decision are both doubtful and, in any event, insufficient to overcome the plain text, legislative history, and administrative interpretation of the Act. The Sixth Circuit stated that it was concerned that, if improper motive need not be shown, it would "effectively reduce the EMTALA to nothing more than a federal remedy for medical malpractice." Pet. App. A12. Insofar as that statement merely represents a disagreement with Congress's decision to embody a limited "reasonableness" standard in the stabilization provision, it is of little import. And in any event the adoption of an "improper motive" requirement would substitute for the legally familiar "reasonableness" standards in EMTALA an entirely indeterminate inquiry, unguided by the statutory text, regarding which motives are "improper." Because improper motive—however interpreted—is neither a necessary nor a sufficient element of a violation of EMTALA's stabilization requirement, the Sixth Circuit's decision should be reversed.

ARGUMENT

A VIOLATION OF 42 U.S.C. 1395dd(b) OCCURS WHEN A COVERED ENTITY FAILS TO STABILIZE A PATIENT BEFORE TRANSFER, REGARDLESS OF THE MOTIVE WITH WHICH THE ENTITY ACTED

A. The Text Of EMTALA Makes Clear That Establishing A Violation Does Not Require Proof Of Motive

The cardinal principle of statutory construction is that statutes should be construed in accordance with their plain language. "Where there is no ambiguity in the words, there is no room for construction." *United States* v. *Gonzales*, 117 S. Ct. 1032, 1036 (1997) (quoting *United States* v. *Wiltberger*, 18 U.S. (5 Wheat.) 76, 95-96 (1820)

(Marshall, C. J.)). Only an "absurd or glaringly unjust result" "would warrant departure from the plain language of" the statute. *Inter-Modal Rail Employees Ass'n* v. *Atchison, T. & S.F. Ry.*, 117 S. Ct. 1513, 1516 (1997) (citation and internal quotation marks omitted).

1. Section 1395dd(b) provides:

> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
>
> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

In the circumstances of this case—which does not involve a transfer that purports to have satisfied subsection (c)—Section 1395dd(b) makes clear that a violation occurs if certain specified conditions are satisfied. First, an individual must have "come to a hospital." Second, the hospital must have determined that the individual has "an emergency medical condition." Third, the hospital must have failed to provide "for such further medical examination and such treatment as may be required to stabilize the medical condition." Fourth, such further examination and treatment must be "within the staff and facilities available at the hospital."

If all of the above conditions are satisfied, a hospital has violated the obligations imposed by the plain language of Section 1395dd(b). None of those conditions can reasonably be read to impose an additional condition that must be satisfied—that the hospital acted with any particular motive. A hospital may have a laudable motive to provide excellent care to its emergency room patients generally,

but it nonetheless may violate Section 1395dd(b) by failing to provide a "further medical examination" and "treatment" that would stabilize a particular patient's condition. Conversely, a hospital may generally intend to discriminate against patients who cannot pay—the immediate concern of the drafters of EMTALA, see pp. 18-19, *infra* — or against patients of another identifiable group, but nonetheless provide a "further medical examination" and "treatment" that stabilize one such patient prior to transfer. If so, the hospital may have violated some other provision of law, but it has not violated this provision of EMTALA. Although evidence of an improper motive may be probative as to various issues in an EMTALA case, the text of EMTALA contains no suggestion that proof of an improper motive is either necessary or sufficient to establish a violation of the "stabilization" requirements of Section 1395dd(b).

2. The definitions of the key terms in Section 1395dd(b) further specify the nature of a violation and the mental state of the party that commits a violation. They, too, make clear that an improper motive is not an element of a violation.

a. The most significant term in Section 1395dd(b) is "to stabilize," since a hospital's basic obligation under that provision is "to stabilize" a patient before transfer. The term "to stabilize" is defined to mean:

> to provide such medical treatment of [an emergency medical] condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman having contractions], to deliver.

42 U.S.C. 1395dd(e)(3)(A). The term "stabilized" is defined in a similar manner. 42 U.S.C. 1395dd(e)(3)(B).

Aside from the case of pregnant women having contractions—for whom special rules apply—the definition of "to stabilize" makes clear that a hospital's basic obligation is to see to it that the patient's emergency medical condition is not likely to deteriorate during, or as a result of, any transfer to another facility. The definition clarifies the mental state with which the hospital must act: it must assure "within reasonable medical probability" that the patient's condition will not likely deteriorate. The hospital is therefore not strictly liable for the patient's condition when it effects a transfer. If it acts "within reasonable medical probability" to assure that the patient's condition will likely suffer no material deterioration, the hospital has satisfied its obligations. Nothing in the definition of "to stabilize" suggests that a hospital that fails to assure "within reasonable medical probability" that a patient's condition will not likely deteriorate during or as a result of a transfer could nevertheless escape liability if the plaintiff fails to show that the hospital acted with some "improper" (presumably non-medical) motive.[4]

b. The statutory definition of the term "emergency medical condition" further supports the conclusion that a

[4] The standard of care under 42 U.S.C. 1395dd(b) is not one of ordinary "reasonableness" (*i.e.*, negligence); it instead requires merely that a hospital stabilize patients "within the staff and facilities available at the hospital." 42 U.S.C. 1395dd(b)(1)(A); accord 42 U.S.C. 1395dd(a) (requiring a hospital to provide an "appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department"). A hospital therefore cannot be held liable under Section 1395dd(b)(1)(A) on the ground that it "negligently" failed to have more specialized staff or facilities at the hospital. The Secretary has the authority under 42 U.S.C. 1395bb to promulgate regulations to further specify, consistent with the Act itself, the obligations of participating hospitals. See 42 C.F.R. 489.24 (responsibilities of participating hospitals in emergency cases).

violation may be established with no proof of an improper motive. That term is defined as

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in —
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part.

42 U.S.C. 1395dd(e)(1)(A).[5]

By once again incorporating a "reasonableness" standard—a failure to give medical attention that "could reasonably be expected" to result in jeopardy to health or impairment of bodily function—this definition reinforces the conclusion that hospitals need not guarantee that patients who come to emergency rooms will be correctly diagnosed and their emergency medical conditions successfully treated. But it also makes clear that hospitals must at least stabilize the conditions of those patients who could reasonably be expected to be placed in jeopardy without such treatment. Certainly the use of the familiar "reasonableness" standard cannot be read to suggest that the hospital will be liable only if it *intends* to treat a pa-

[5] A companion provision adds that a pregnant woman who is experiencing contractions has an emergency medical condition if "there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child." 42 U.S.C. 1395dd(e)(1)(B).

tient improperly or otherwise acts with an improper motive.[6]

3. As originally enacted, the sanctions under EMTALA included suspension or termination from the Medicare program, which could be imposed on a hospital that "knowingly and willfully, or negligently, fail[ed] to meet the requirements of [EMTALA]." 42 U.S.C. 1395dd(d)(1) (1988). If, as the Sixth Circuit held, violations of EMTALA require proof of improper motive, there could be no possibility of a "negligent" violation of the Act, and the use of the term "negligently" in the sanction provision would have been superfluous. See, *e.g.*, *Walters* v. *Metropolitan Educ. Enters.*, 117 S. Ct. 660, 664 (1997) ("Statutes must be interpreted, if possible, to give each word some operative effect."). Because, however, EMTALA from the beginning imposed requirements that did not turn on the presence of improper motive, the sanction provision's reference to negligence fits comfortably with the balance of the Act, permitting imposition of sanctions even when a hospital is at fault but cannot be shown to have acted with an improper motive.

---

[6] EMTALA's provisions setting forth the alternative to the stabilization requirement also indicate that the statutory duty turns on objective factors, not the motive-based analysis adopted by the Sixth Circuit. Under those provisions, a hospital may transfer a patient whose condition has not been stabilized if a physician "has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual * * * from effecting the transfer." 42 U.S.C. 1395dd(c)(1)(A)(ii). The statutory duty thus is based upon an analysis of what is "reasonably expected"—not the motive with which the hospital or physician made the transfer. Similarly, Section 1395dd(d)(1)(B)(i) imposes liability on a physician who signed such a certificate "if the physician knew or should have known that the benefits did not outweigh the risks." The "should have known" standard suggests that the physician's duty is not merely to refrain from acting with an improper motive.

In amendments added by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Pub. L. No. 101-508, Tit. IV, § 4008(b)(3)(A) and (B), 104 Stat. 1388-44, the EMTALA provision regarding termination or exclusion from Medicare was repealed, and it was replaced by the incorporation of more general provisions permitting the Secretary of Health and Human Services to terminate from the Medicare program a participating hospital that fails to fulfill its obligation to comply substantially with the provisions of its provider agreement, including the commitment to comply with EMTALA. See 42 U.S.C. 1395cc(a)(1) and (a)(1)(I), 1395cc(b)(2) and (b)(2)(A). At the same time, however, Congress amended the EMTALA civil penalty provisions. Under EMTALA as originally enacted, the Secretary could impose civil monetary penalties on hospitals and physicians who "knowingly violate[d] a requirement of [EMTALA]." 42 U.S.C. 1395dd(d)(2) (1988). In OBRA 1990, Congress substituted the term "negligently" for the term "knowingly" in that provision. Tit. IV, § 4008(b)(1), 104 Stat. 1388-44. That change would be inexplicable if EMTALA could only be violated by a hospital that acted with an improper motive.[7] See

---

[7] In OBRA 1990, Congress also provided for the first time that, "[i]n considering allegations of violations of [EMTALA] in imposing [civil penalties]," the Secretary shall "request the appropriate utilization and quality control peer review organization [PRO] * * * to assess whether the individual involved had an emergency medical condition which had not been stabilized." OBRA 1990, § 4027(a)(1)(A), 104 Stat. 1399-117, codified at 42 U.S.C. 1395dd(d)(3). The role of the PRO is to address quality of care issues — not motivation. See 42 C.F.R. 489.24(g)(2)(v) (PRO should provide an "expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case."). Congress's decision to require use of the PRO mechanism in civil penalty actions under EMTALA further supports the conclusion that Congress understood that EMTALA liability is

American Nat'l Red Cross v. *S.G.*, 505 U.S. 247, 263 (1992) ("canon[s] of statutory construction requir[e] a change in language to be read, if possible, to have some effect") (internal citations omitted). But the change is entirely explicable if the Act can be violated by hospitals that negligently fail to stabilize a patient before transfer. In that event, the amendment expressed Congress's reasonable decision in 1990 that the enforcement mechanism of civil penalties would be useful to deter such negligent violations.[8]

B. The Legislative History Of EMTALA Supports The Conclusion That A Hospital's Obligations Under Section 1395dd(b) Do Not Turn On The Motive With Which The Hospital Acts

1. EMTALA was originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985

based on adherence to a medical standard of care, not subjective motivation. Indeed, Medicare providers generally have an obligation to provide services of "a quality which meets professionally recognized standards of care." 42 U.S.C. 1320c-5(a)(1).

[8] Since its enactment, EMTALA's private right of action provision has specified only that an individual or a medical facility suffering "personal harm" or "a financial loss" as a direct result of a violation may bring a private suit for damages or equitable relief. 42 U.S.C. 1395dd(d)(2)(A) and (B). Although that provision does not itself specify "negligence" or any other standard to govern such an action, we believe that the EMTALA provisions cited above that define a hospital's obligations in terms of reasonableness make clear that a private suit based on an asserted violation of Section 1395dd(b) must rest at least on an allegation of negligence with respect to the duties imposed by those provisions. Whether there are obligations imposed by other provisions of EMTALA that would support a private suit not resting on a negligence standard is not at issue in this case and has not been extensively litigated in the lower courts. Cf. *Vargas* v. *Del Puerto Hosp.*, 98 F.3d 1202, 1206 (9th Cir. 1996) (holding hospital not liable "for what amounts to a clerical deficiency in record-keeping where the evidence indicates that the transfer was effected for medical reasons").

(COBRA 1985), Pub. L. No. 99-272, Tit. IX, § 9121(b), 100 Stat. 164. It arose from "a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, at 5 (1985). See also H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 27 (1985) (Congress was "greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."). In some cases, "treatment was simply not provided," while in others "patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital." *Ibid.* That practice was known as "patient dumping."

2. Although Congress's principal concern in enacting EMTALA was the problem of patient dumping, Congress had available a number of possible means to address that problem. "[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed." *Oncale* v. *Sundowner Offshore Servs., Inc.*, 118 S. Ct. 998, 1002 (1998). Thus, the fact that Congress was concerned with patient dumping does not establish just how it chose to address that problem or what substantive obligations it chose to impose on hospitals to ensure that proper care is provided.

Congress surely could have enacted a statute prohibiting intentional discrimination against certain classes of patients. Had it done so, however, it is reasonable to expect that the statute would include some language embodying the discrimination standard or otherwise indicating that such a standard was intended. EMTALA contains no such language. Because differences in treatment (for example, among patients suffering different medical conditions) cannot all be prohibited, it would also

be expected that Congress would specify precisely which types of intentional discrimination—*i.e.*, which motives—were prohibited. Yet EMTALA contains no specification of which types of discrimination would be prohibited, and it otherwise offers a court no help in determining which "motives" might be considered "improper," and thus the basis for a violation.[9] The logical conclusion to be drawn from the absence of any such specification is that Congress chose not to take the approach of forbidding discrimination based on improper subjective motives when it enacted EMTALA.

3. Instead of addressing the problem of patient dumping through a motive-based prohibition, Congress chose to require hospitals to satisfy a substantive standard of care. It would obviously have been difficult or impossible to specify the precise minimum procedures that hospitals must use to treat each of the myriad emergency medical conditions they face in emergency rooms. Accordingly, Congress chose instead to impose a general "reasonableness" standard, not unfamiliar in other areas of law, but

---

[9] The Sixth Circuit itself has stated that improper motives include the patient's "indigency or lack of insurance[,] * * * race, sex, politics, occupation, education, personal prejudice, drunkenness, or spite," Pet. App. A11, and "prejudice against the * * * ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition," *id.* at A9-A10. The Sixth Circuit did not explain how it determined that these were improper motives or whether other motives—such as a desire to limit treatment based on local residency or medical condition—would also be "improper" under EMTALA. Moreover, limiting EMTALA's coverage to individuals whose personal characteristics might trigger substandard care on one of the grounds identified by the Sixth Circuit would be inconsistent with EMTALA's statements that its duties are owed by hospitals to "any individual" who seeks medical treatment or is found to have an emergency condition. See *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991).

with modifications—such as the need for a hospital only to act within its available personnel and facilities, see note 4, *supra* — to suit the present context.

The Conference Report on EMTALA made clear that it was adopting the House proposal that "all participating hospitals must * * * provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor." H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 473 (1985). That is not a motive-based standard. Moreover, although the House bill required provision of "medical treatment * * * to assure that no material deterioration of the [emergency medical] condition is likely to result from the transfer of the individual," the Senate bill added that the treatment must only provide such assurance "within reasonable medical probability." *Id.* at 477. The Conference Committee adopted the House provision, but modified it with the Senate's "within reasonable medical probability" standard. *Id.* at 478. That compromise demonstrates that Congress focused on the precise standard of care to be embodied in EMTALA, and concluded that, while an absolute guarantee of medical results would be too exacting, a "medical reasonableness" standard would provide sufficient protection against patient dumping.

The Senate floor debates on the bill similarly leave no doubt that Congress chose to address the problem of emergency treatment and stabilization by imposing a medical standard of care—not merely a prohibition against intentional discrimination—on participating hospitals.[10] Senator Durenberger, the bill's floor manager, stated that the bill would "make it clear that the Medicare Program will not do business with any institution which willfully and knowingly, *or through negligence*, turns its back on an

---

[10] The debate on COBRA on the House floor rarely touched on EMTALA, and it does not clarify the instant question. See 131 Cong. Rec. 29,829 (1985) (Rep. Stark), 19,833 (Rep. Bilirakis), 29,835 (Rep. Madigan).

emergency medical situation." 131 Cong. Rec. 28,568 (1985) (emphasis added). Senator Kennedy, a co-sponsor, similarly stated that "every patient who has a bonafide emergency must receive stabilizing care." *Id.* at 28,569. Senator Dole, another co-sponsor, referred to the problem of patient dumping, and added that "a hospital is charged only with the responsibility of providing an adequate first response to a medical crisis," which "means that a patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient." *Ibid.* Those statements evidence Congress's intent to address the problem of patient dumping by imposing a medical standard of care, not a prohibition against intentional discrimination.

4. EMTALA has been amended on several occasions since 1986. Aside from the amendment to the civil penalty provision in 1990 (see pp. 17-18, *supra*), most of those amendments did not address the nature of the duty imposed by EMTALA on participating hospitals. But on each occasion, the discussions in the committee reports concerning EMTALA's requirements referred only to the hospital's duty to provide sufficient care to stabilize the patient's condition.[11] They nowhere suggested that improper motive is an element of a statutory violation.

---

[11] See, *e.g.*, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4009(a), 101 Stat. 1330-56 to 1330-57, discussed in H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. 540, 543, 547 (1987) (describing EMTALA as requiring a hospital to "provide, within its capabilities, examination and treatment to stabilize the medical condition or to administer [*sic*] to the labor," and leaving that standard unchanged); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, Tit. VI, § 6211(a), 103 Stat. 2245, discussed in H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 835, 837, 839 (1989) (describing EMTALA as requiring hospitals to "provide medical services necessary to stabilize the individual or to provide for treatment of the labor," and leaving that standard unchanged).

C. The Secretary Of Health And Human Services Also Has Taken The Position That "Improper Motive" Is Not An Element Of An EMTALA Violation

As noted previously, p. 4, *supra*, the Secretary of Health and Human Services administers the civil monetary fine provisions of EMTALA, and she may also exclude physicians who violate EMTALA from eligibility for Medicare or Medicaid reimbursements. Similarly, the Secretary may terminate a hospital's eligibility for federal reimbursements if the hospital violates EMTALA. Because the Secretary has an important role in the administration of EMTALA, her interpretation of EMTALA is entitled to deference. See *Martin* v. *OSHRC*, 499 U.S. 144 (1991); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-845 (1984).

The Secretary has concluded that proof of an improper motive is not an essential element of a violation of Section 1395dd(b). In the preamble to Interim Final Rules and Regulations that remain in effect and that govern the Department's Health Care Financing Administration and its Office of Inspector General, the Secretary stated that "with regard to appropriate transfers, * * * the Secretary has taken the position that in proving that a hospital or physician has violated [42 U.S.C. 1395dd(b)], there is no requirement to prove that the transfer was effected due to some 'impermissible motive.'" 59 Fed. Reg. 32,086, 32,104 (1994). As the Secretary explained, that position was not a new one, since it had already been upheld by the Fifth Circuit three years earlier in *Burditt* v. *HHS*, 934 F.2d 1362 (5th Cir. 1991). Thus, even if the text and legislative history of 42 U.S.C. 1395dd(b) were ambiguous, the Secretary's reasonable interpretation that

proof of a violation does not require proof of an improper motive would settle the matter.

D. There Is Nothing In The "Appropriate Medical Screening Examination" Provision Of EMTALA, 42 U.S.C. 1395dd(a), That Supports An Improper Motive Requirement In Section 1395dd(b)

Rather than purporting to find any language in Section 1395dd(b) that could be construed to impose an improper motive requirement, the Sixth Circuit relied heavily on its prior decision in *Cleland*, which arose under Section 1395dd(a)'s "appropriate medical screening" provision. *Cleland* held that " 'appropriate' must * * * be interpreted to refer to the motives with which the hospital acts." 917 F.2d at 272. The court in this case applied that holding to Section 1395dd(b) because it "s[aw] no rational reason to set forth differing standards when applying subsection[s] (a) and (b)." Pet. App. A12 n.3. Accordingly, the Sixth Circuit's conclusion with respect to subsection (b) of Section 1395dd that "a plaintiff [must] prove a hospital acted with an improper motive in order to recover under the EMTALA," *id.* at A10, rests, at bottom, on its construction in *Cleland* of the term "appropriate medical screening" in subsection (a).

1. The Sixth Circuit erred in concluding that there is no "rational reason" to impose differing liability standards under the "appropriate medical screening examination" (subsection (a)) and "stabilization" (subsection (b)) provisions of EMTALA. Even if the Sixth Circuit were correct that the term "appropriate" in subsection (a) could be construed as imposing an improper motive requirement, neither the term "appropriate" nor any similar term appears in subsection (b). Because no other term in subsection (b) can plausibly be read to impose an improper motive requirement, the difference in statutory language would be a more than sufficient basis for concluding that, regardless of the obligations imposed by subsection (a),

liability under subsection (b) does not turn on proof of an improper motive.

2. More fundamentally, the Sixth Circuit erred in apparently construing an "appropriate medical screening examination" under subsection (a) to include an examination that is medically inefficacious and unreasonable but that is conducted with a "proper" motive. The word "appropriate" is susceptible to a wide range of meanings, but construing it to mean "without improper motivation" is to confer on the word a meaning not found in any standard dictionary and not known to common usage.[12] Respondent cites no case, and we are aware of none, in which a court has construed the word "appropriate" as used in any other statute to mean "without improper motivation."[13]

All three other courts of appeals to address the issue have rejected the Sixth Circuit's holding that proof of a violation of the subsection (a) "appropriate medical screening examination" requirement requires proof of an improper motive.[14] In addition, four other courts of appeals have discussed the scope of EMTALA liability under subsection (a) with no mention of an improper motive re-

---

[12] See, *e.g.*, *The Random House Dictionary of the English Language* 103 (2d ed. 1987) (defining "appropriate" as "suitable or fitting for a particular purpose, person, occasion"); *Webster's Third New International Dictionary* 106 (1976) ("specially suitable: fit, proper").

[13] Cf. *Board of Educ. of the Hendrick Hudson Cent. Sch. Dist.* v. *Rowley*, 458 U.S. 176, 188-189 (1982) (construing "free appropriate public education" for a handicapped child to mean "educational instruction specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child 'to benefit' from the instruction").

[14] See *Gatewood* v. *Washington Health Care Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Power* v. *Arlington Hosp. Ass'n.*, 42 F.3d 851, 857 (4th Cir. 1994); *Summers* v. *Baptist Med. Cent. Arkadelphia*, 91 F.3d 1132, 1137-1138 (8th Cir. 1996) (en banc).

quirement.[15] Each of those courts has construed the term "appropriate" in 42 U.S.C. 1395dd(a) to refer to the type of screening provided to an emergency room patient, not to the motivation underlying a medical screening that fails to satisfy a standard of medical suitability.

Aside from rejecting the Sixth Circuit's improper motive requirement, the courts of appeals have differed regarding whether the "appropriate medical screening examination" requirement imposes merely an obligation that each participating hospital screen all patients for the existence of an emergency medical condition equally, or whether it also imposes a substantive minimum standard of care. Compare, *e.g.*, *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) (screening must be "reasonably calculated to identify critical medical conditions") and *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("The touchstone is whether * * * the [screening] procedure is designed to identify an 'emergency medical condition,' that is manifested by 'acute' and 'severe' symptoms.") with *Summers* v. *Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996) ("An inappropriate screening examination is one that has a disparate impact on the plaintiff.") and *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) ("As long as a hospital applies the same screening procedures to indigent patients [as] it applies to paying patients, the hospital does not violate [Section 1395dd(a).").

To some extent, the differences among the circuits on this point may be more apparent than real. Hospitals can be expected generally to provide medically reasonable care to their patients, both because professional medical

[15] See *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995); *Repp* v. *Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); see also *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143 (4th Cir. 1996).

standards require such care and because of the threat of tort liability under state law. Thus, a hospital that provides the same procedures for determining the existence of an emergency medical condition to indigent patients as to paying patients may ordinarily be expected to be found to have given medically reasonable care to all. The Secretary of Health and Human Services has stated, however, that the "appropriate medical screening examination" provision of EMTALA requires screening examinations that are both equal in the relevant respects to those provided to other patients and, at a minimum, adequate to determine whether an individual is suffering from an emergency medical condition.[16] As noted above, her view

[16] In the preamble to the Interim Final Rules and Regulations cited previously (see p. 23, *supra*), the Secretary declined to define the term "appropriate medical screening examination" because of the wide range of medical conditions presented to emergency rooms and the wide range of capabilities in facilities and personnel available to hospitals. But she stated that, "[w]ithin those capabilities, the examination must be sufficient to permit the hospital to decide whether or not the individual has an emergency medical condition." 59 Fed. Reg. 32,086, 32,099 (1994); see also Department of Health and Human Services, Health Care Financing Administration, *State Operations Manual: Provider Certification*, at V-19 (1998). Discussing whether hospitals could maintain procedures requiring emergency room personnel to ask emergency room patients whether they had insurance without violating EMTALA, she stated that such a practice was acceptable "as long as all individuals to whom the procedures apply are treated similarly. That is, all individuals who have an emergency medical condition are served regardless of the answers they may give to insurance questions during routine admission screening." 59 Fed. Reg. at 32,099. See also *id.* at 32,100 ("The thrust of the statute is that a hospital that offers emergency services to some members of a community who need their emergency services (for example, those that can pay) cannot deny such services to other members of the community with a similar need."); *State Operations Manual: Provider Certification*, *supra*, at V-19 ("The medical screening examination must be the same medical screening examination that the

is entitled to deference. But whatever may be the correct interpretation of the "appropriate medical screening examination" requirement in subsection (a) of EMTALA, the Sixth Circuit's rule that improper motive be shown under that provision is at odds with the views of each of the other circuits that has considered the issue and with the views of the Secretary, which should be controlling on this point.

3. The Sixth Circuit stated that one reason for requiring improper motive to be shown in an action under both subsection (a) and subsection (b) was that dispensing with proof of improper motive and resting a claim under EMTALA solely on a lack of uniform treatment would "effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable standard of care with respect to all similarly situated patients." Pet. App. A11. Presumably, the court was referring to a case in which the plaintiff proves that the hospital breached a medical standard of care. In such a case, the court believed that the hospital would be placed in the "precarious position" of having to prove that it committed the same breach with respect to all of its patients. *Ibid.*

The Sixth Circuit's policy concerns are not sufficient to overcome the plain language, history, and authoritative administrative construction of subsection (b) of EMTALA. Those policy concerns also rest on a false dilemma. If EMTALA merely required uniform treatment of patients with similar medical conditions, the issue of negligence would be irrelevant. If the plaintiff nonetheless argued that the hospital's care was substandard, the hospital could be expected to respond that the treatment it provided to the plaintiff and to all of its patients is satisfactory; the hospital surely would not have to admit (or prove) that it

---

hospital would perform on any individual coming to the hospital's emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care.").

was negligent with respect to anyone. More fundamentally, as we have explained above (see pp. 12-16, *supra*), EMTALA imposes minimum substantive standards of medical care under both subsections (a) and (b). Thus, a hospital would defend against an EMTALA subsection (b) suit by proving that, within the available staff and facilities, the hospital had stabilized the condition of the patient "within reasonable medical probability." 42 U.S.C. 1395dd(e)(3)(A). Because that is akin to the kind of negligence standard that is familiar in state tort law, it puts hospitals in no more "precarious position" than does state tort law. Indeed, it is far easier to use well-developed standards of medical reasonableness to assess conduct in an EMTALA suit than it would be to determine—with no help from the statutory language—just which motives for differential treatment were "improper" under the Sixth Circuit's open-ended test.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
FRANK W. HUNGER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General
BARBARA C. BIDDLE
CARL E. GOLDFARB
Attorneys

JULY 1998

Supreme Court, U.S.
FILED
JUL 23 1998
OFFICE OF THE CLERK

No. 97-53

In The

Supreme Court of the United States

October Term, 1997

JANE M. ROBERTS, Guardian for WANDA Y. JOHNSON,

Petitioner,

v.

GALEN OF VIRGINIA, INC., formerly d/b/a HUMANA HOSPITAL — UNIVERSITY OF LOUISVILLE, d/b/a LOUISVILLE HOSPITAL,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF *AMICI CURIAE* NOW LEGAL DEFENSE AND EDUCATION FUND, AMERICAN CIVIL LIBERTIES UNION WOMEN'S RIGHTS PROJECT, NATIONAL ORGANIZATION FOR WOMEN FOUNDATION, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, NATIONAL WOMEN'S HEALTH NETWORK, AND NATIONAL WOMEN'S LAW CENTER IN SUPPORT OF PETITIONER

M. ELAINE JOHNSTON
200 Haven Avenue
New York, New York 10033
(212) 543-2776

MARTHA F. DAVIS
Counsel of Record
NOW LEGAL DEFENSE AND EDUCATION FUND
99 Hudson Street
12th Floor
New York, New York 10013
(212) 925-6635

Attorneys for Amici Curiae

RECEIVED
JUL 24 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

147553 (800) 274-3321 • (800) 359-6859
A DIVISION OF COUNSEL PRESS
Lutz Appellate Services, inc.

31 pp

TABLE OF CONTENTS

	Page
Table of Citations	ii
Interest of *Amici Curiae*	1
Summary of Argument	3
Argument	5
I. On Its Face, EMTALA Does Not Require A Plaintiff To Prove An Improper Motive On The Part Of The Hospital And The Creation Of Such A Requirement Would Vitiate The Purpose Of The Statute.	5
A. The Plain Words Of The Statute Prohibit Inappropriate Transfers Without Regard To The Motivation Of The Hospital.	5
B. Congress Was Aware of Analogous Federal and State Laws That Explicitly Require Proof Of Improper Intent And Deliberately Chose Not To Enact Such A Requirement In EMTALA.	11
II. Imposition Of A Requirement That A Plaintiff Prove The Motivation Of The Health Care Provider Would Substantially Weaken EMTALA, Contravening Congress's Intent To Provide An Effective Means Of Enforcement.	14

Contents

	Page
A. The Burden of Proving The Motivation Of The Hospital Would Be Prohibitively High And Would Undermine Effective Enforcement Of The Statute.	14
B. The Added Burden Of Proof Would Endanger The Lives Of Those In Need Of Emergency Care.	15
Conclusion	21

TABLE OF CITATIONS

Cases Cited:

Atlantic Cleaners & Dyers v. United States, 286 U.S. 427 (1932) 8

Brogan v. United States, 118 S. Ct. 805 (1998) 6

Burditt v. U.S. Dep't of Health and Human Services, 934 F.2d 1362 (5th Cir. 1991) 1, 9, 10, 18, 20

Cleland v. Bronson Health Care Group, 917 F.2d 266 (6th Cir. 1990) 6, 8

Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991) 9, 10

Hawkins v. Town of Shaw, 461 F.2d 1171 (5th Cir. 1972) 14

Contents

	Page
In re Margaret R. Pardee Memorial Hospital, (Hendersonville, N.C.; HHS/OCR No. 04803173, decided Sept. 4, 1981)	12
Metropolitan Hous. Dev. Corp. v. Village of Arlington Heights, 558 F.2d 1283 (7th Cir. 1977), *cert. denied*, 434 U.S. 1025 (1978)	14
North Haven Bd. of Educ. v. Bell, 456 U.S. 512 (1982)	11
Oncale v. Sundowner Offshore Services, Inc., 118 S. Ct. 998 (1998)	6
Power v. Arlington Hosp. Ass'n, 42 F.3d 851 (4th Cir. 1994)	9, 10, 14
Roberts v. Galen of Virginia, Inc., 111 F.3d 405 (6th Cir. 1997)	5, 6, 7, 8
Schenck v. Pro-Choice Network, 117 S. Ct. 855 (1997)	1
Summers v. Baptist Medical Ctr. Arkadelphia, 91 F.3d 1132 (8th Cir. 1996)	9, 10
Washington v. Dunn, 916 P.2d 952 (Wash. Ct. App. 1996), *rev. denied*, 928 P.2d 413 (Wash. 1996)	1

Contents

	Page
Statutes Cited:	
42 U.S.C. §§ 291, *et seq.*	11
42 U.S.C. § 1395dd	3, 4, 5
42 U.S.C. § 1395dd(a)	5, 7
42 U.S.C. § 1395dd(c)(2)	5, 7
42 U.S.C. § 1395dd(c)(2)(D)	7
42 U.S.C. § 1395dd(c)(2)(E)	5
42 U.S.C. § 1395dd(d)(1)	5, 10
42 U.S.C. § 1395dd(d)(2)(A)	6, 10
42 U.S.C. § 1395dd(e)(1)(B)	19
42 U.S.C. § 1395dd(e)(3)(A)	8
42 U.S.C. § 1395dd(e)(3)(B)	8
Act of Oct. 21, 1986, Pub. L. No. 99-509, tit. IX, § 9307(c)(4), 100 Stat. 1996	10
Act of Dec. 22, 1987, Pub. L. No. 100-203, tit. IV, § 4009(a), 101 Stat. 1330-56, 1330-57	10

Contents

	Page
Act of Oct. 13, 1988, Pub. L. No. 100-485, tit. VI, § 608(d)(18)(E), 102 Stat. 2419	10
Act of Dec. 19, 1989, Pub. L. No. 101-239, tit. VI, §§ 6003(g)(3)(D)(xiv), 6211, 103 Stat. 2154, 2245	10
Act of Nov. 5, 1990, Pub. L. No. 101-508, tit. IV, §§ 4008(b)(1)-(3)(A), 4207(a)(1)(A), (2), (3), (k)(3), 104 Stat. 1388-44, 1288-117, 1388-124	10
Act of Oct. 31, 1994, Pub. L. No. 103-432 tit. I, § 160(d)(4), (5)(A), 108 Stat. 4444	10
Act of Aug. 5, 1997, Pub. L. No. 105-33, tit. IV, § 4201, 111 Stat. 373	10
Section 1867 of the Consolidated Omnibus Reconciliation Act of 1986, Pub. L. No. 99-272	3
Cal. Health and Safety Code §§ 1317, 17409, 1978	11
Colo. Rev. Stat. §§ 26-15-101-110	11
Fla. Stat. Ann. §§ 395.0143, 401.45(1)	11
Ga. Code. Ann. §§ 31-8-42, 31-8-43, 31-8-46	11
Hawaii Rev. Stat. § 321-232(b)	11, 13
Ill. Ann. Stat. Ch. 111 ½, § 86	11

Contents

	Page
Ky. Rev. Stat. Ann. § 216B.400(1)	11
Ky. Rev. Stat. Ann. § 216B.990(3)	11
La. Rev. Stat. Ann. §§ 2113.4(2)-2113.4(b)	11
Mass. Gen. Laws Ann. § 70E(m)(e)	11
Mich. Stat. Ann. § 14.15(20703)	11
Mich. Stat. Ann. § 14.15(20704(4))	11
Mich. Stat. Ann. § 14.15(20715)	11
Mo. Ann. Stat. § 205.989(1)	11
N.J. Admin. Code tit. 8, § 8.43-B1	11
N.Y. Public Health Law § 2805-b	11
N.Y. Public Health Law § 2806(1)	11
Oregon Admin. Reg. Ch. 333, § 23(15)	11
Pa. Admin. Reg. § 117.1(a), (b)	11
R.I. Gen. Laws § 23-17-26(a)	11
S.C. Admin. Reg. 61-16 § 309	11
Tenn. Code Ann. § 68-39-302	11

Contents

	Page
Tenn. Code Ann. § 68-69-301	11
Tenn. Code Ann. § 68-39-511(12)	11
Tex. Health & Safety Code Ann. § 311.022 (1998 Supp.)	13
Tex. Health & Safety Code Ann. § 4438	11
Utah Code Ann. § 26-8-2(12)	11
Utah Code Ann. § 26-8-8(1)	11
Wis. Stat. Ann. § 146.301	11
Wyo. Stat. Ann. § 35-2-115(a)	11
Rule Cited:	
Supreme Court Rule 37.6	1
Other Authorities Cited:	
42 C.F.R. § 124.603(b)(1)	12
H.R. Rep. 241, 99th Cong., 1st Sess., pt. 3, at 5, *reprinted in* 1986 U.S.C.C.A.N. 726	13
N.Y. Pub. Health Law § 2805-b (McKinney 1993)	13
S. Rep. No. 1285, 93rd Cong., 2d Sess. 61, *reprinted in* 1974 U.S.C.C.A.N. 7842	12

Page

Bureau of the Census, Current Population Reports, Series P60-198, *Poverty in the United States: 1996* tbl. 2 (1997) 17, 19

Bureau of the Census, Current Population Reports, Series P60-199, *Health Insurance Coverage: 1996* (1997) 17

Bureau of the Census, *Statistical Abstract of the United States: 1997*, at tbl. 171 ..... 19, 20

Bureau of Labor Statistics, U.S. Department of Labor, *Geographic Profile of Employment and Unemployment 1996* tbl. 2 (1998) 17

Equal Access to Health Care: Patient Dumping: Hearing Before the Human Resources & Intergovernmental Relations Subcomm. of the House Comm. on Government Operations, 100th Cong., 1st Sess. 40 (1987) 6

Institute for Women's Policy Research, Research in Brief, *Women's Access to Health Insurance* (1996) 17

The Urban Institute, *State-Level Datebook on Health Care Access and Financing* (3d ed. 1998) 17

Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 Health Matrix 3 (1998) 20

Page

Lauren Dame & Sidney Wolfe, Public Citizen Health Research Group, *Hospital Violations of the Emergency Medical Treatment and Active Labor Act: A Detailed Look at "Patient Dumping,"* app. 1 (Dec. 1997) ... 19, 20

Marilyn Ellwood and Leighton Ku, *Welfare and Immigration Reforms: Unintended Side Effects for Medicaid*, 17 Health Affairs 137, 143 (May/June 1998) 18

David U. Himmelstein, *et al.*, *Patient Transfers: Medical Practice as Social Triage*, 74 Am. J. Public Health 494 (1984) 15

Robert L. Schiff, *et al.*, *Transfers to a Public Hospital*, 314 New Eng. J. Med. 552 (1986) 15, 18, 19

Sutherland, *Statutory Construction* § 47.16 8

Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186 (1986) 11, 12

INTEREST OF *AMICI CURIAE*

The NOW LEGAL DEFENSE AND EDUCATION FUND ("NOW LDEF"), founded in 1970 by leaders of the National Organization for Women, is a non-profit civil rights organization that performs a broad range of legal and educational services nationally in support of women's efforts to secure equal rights. One of NOW LDEF's priorities is the protection of the health of all women, particularly low-income women and women of color, and NOW LDEF has participated in numerous cases designed to effectuate that goal. *See, e.g., Schenck v. Pro-Choice Network*, 117 S. Ct. 855 (1997); *Burditt v. U.S. Dep't of Health and Human Services*, 934 F.2d 1362 (5th Cir. 1991); and *Washington v. Dunn*, 916 P.2d 952 (Wash. Ct. App. 1996), *rev. denied*, 928 P.2d 413 (Wash. 1996). Because the instant case directly implicates the access of poor and uninsured women to adequate health care and to treatment for emergency conditions, NOW LDEF seeks to participate as *amicus curiae* in support of petitioner.[1]

The AMERICAN CIVIL LIBERTIES UNION is a nationwide, non-partisan organization of more than 300,000 members dedicated to preserving the Bill of Rights. The ACLU WOMEN'S RIGHTS PROJECT ("ACLU WRP"), founded in 1971, has been a leader in the efforts to eliminate the barriers to women's full equality in American society. Equal access to health care for all women, particularly young women, pregnant women, poor women and women of color, is a priority for the ACLU

---

1. Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part and that no person, other than *amici*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

This brief is submitted with the consent of all the parties and letters of consent from counsel for the parties have been lodged with the Clerk.

WRP. The ACLU WRP joins this brief because this case will have a significant impact on the accessibility of health care for all women, especially the uninsured and those in need of emergency care.

The NATIONAL ORGANIZATION FOR WOMEN FOUNDATION ("NOW Foundation") is a 501(c)(3) organization devoted to furthering women's rights through education and litigation. NOW Foundation is affiliated with the National Organization for Women, the largest feminist organization in the United States, with a membership of over 200,000 women and men in more than 600 chapters in all fifty states and the District of Columbia. Since its inception in 1986, a major goal of NOW Foundation has been to ensure full equality for women, including reproductive freedom and fair treatment in health care services. In furtherance of that goal, NOW Foundation has supported related litigation and legislation, and has an ongoing interest in the full and fair health coverage for pregnant women.

The NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES is a non-profit, non-partisan organization that uses public education and advocacy to promote fairness in the workplace, access to quality, affordable health care, and policies that help women and men meet the dual demands of work and family. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership is a voice for women in the managed care debate, promotes access to the full range of reproductive health services, works to prevent discrimination in health care and insurance based on genetic information and other factors, and works to expand health services for low-income women and children.

The NATIONAL WOMEN'S HEALTH NETWORK ("Network") is a non-profit health advocacy organization

founded in 1976 to give women a greater voice in the health care system in the United States. The Network advocates for better federal policy on women's health and, through its Information Clearinghouse, provides women with information and resources to assist them in making better health care decisions. The Network, which is supported by 12,000 individual and 300 organizational members, accepts no funding from either pharmaceutical or device manufacturers. The Network focuses its advocacy efforts on improving access to health care for all women. Access to adequate health care and for treatment of emergency conditions for poor and uninsured women is at the heart of this case. For this reason, the Network has signed onto this brief in support of the petitioner.

The NATIONAL WOMEN'S LAW CENTER ("Center") is a non-profit legal advocacy organization that has been working since 1972 to advance and protect women's legal rights. The Center's primary goal is to ensure that public and private sector practices and policies better reflect the needs and rights of women. Access to quality health care remains an elusive goal for many women, especially for poor women, and advocating for better access to quality health care for women is an important Center priority.

SUMMARY OF ARGUMENT

The Emergency Medical Treatment and Active Labor Act (section 1867 of the Consolidated Omnibus Reconciliation Act of 1986, Pub. L. No. 99-272), 42 U.S.C. § 1395dd (hereinafter "EMTALA"), requires hospitals participating in the Medicare program to provide "an appropriate medical screening" to "any individual" who comes to the emergency department. If the hospital determines that the individual has an emergency medical condition, including active labor, the hospital must provide "such treatment as may be required to stabilize the medical condition."

Id. There are significant limitations on the transfer of unstabilized patients. *See id.* An individual who suffers personal harm as a result of a hospital's violation of EMTALA may bring a civil action for damages against the hospital under the law of the state where the hospital is located.

One of Congress' primary aims in enacting EMTALA was to deter hospitals and doctors from refusing to provide care to the poor and the uninsured. In drafting the statute, however, Congress expanded upon the scope of prior federal and state statutes and enhanced EMTALA's deterrent effect by protecting "any individual" who presents at an emergency room, not just those who are indigent, uninsured, or in some other protected category. As every Circuit Court of Appeals other than the Sixth Circuit which has considered the question has concluded, EMTALA does not require proof that the refusal to provide the statutorily required screening or treatment was improperly motivated.

Requiring proof of an improper motive would both contravene the plain words of the statute and undermine Congress's purpose in enacting EMTALA. Congress responded to dire reports of patients who were inappropriately turned away from emergency rooms or transferred in unstable medical condition — i.e., examples of "dumping," practices that have particularly harsh consequences for African-Americans, Hispanics, and pregnant women — by requiring claimants to prove only one essential element: denial of emergency care. Imposing a higher standard of proof would make it more difficult for plaintiffs to prevail on an EMTALA claim, thwart Congress's purpose in enacting EMTALA, and inevitably lead to another litany of tragic stories, with hospitals continuing to deny services to individuals in need of emergency care.

ARGUMENT

I.

ON ITS FACE, EMTALA DOES NOT REQUIRE A PLAINTIFF TO PROVE AN IMPROPER MOTIVE ON THE PART OF THE HOSPITAL AND THE CREATION OF SUCH A REQUIREMENT WOULD VITIATE THE PURPOSE OF THE STATUTE.

A. The Plain Words Of The Statute Prohibit Inappropriate Transfers Without Regard To The Motivation Of The Hospital.

The decision below, *Roberts v. Galen of Virginia, Inc.*, 111 F.3d 405, Jt. App. A1 (6th Cir. 1997), requires that a plaintiff seeking to recover damages under EMTALA prove that a hospital which ordered an inappropriate transfer of an unstabilized patient had an improper motive for effectuating the transfer.[2] Contrary to the Sixth Circuit's holding, however,

2. § 1395dd(a) of EMTALA provides, in pertinent part, that

> [if] any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for an examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.

§ 1395dd(a). In addition, if "any individual" is determined to have an emergency condition or to be in active labor, the hospital must either provide further treatment to stabilize the medical condition or an "appropriate transfer," as defined in § 1395dd(c)(2), which meets the "interest of the health and safety of individuals transferred." § 1395dd(c)(2)(E). Negligent failure to comply with these requirements exposes the hospital to civil penalties. § 1395dd(d)(1). An individual who suffers personal harm as a result of a hospital's violation of EMTALA may bring a civil action against the hospital under the law of the state where the hospital is located. § 1395dd(d)(2).

the plain words of EMTALA establish no requirement of an improper motive as an element of recovery in a civil action. Congress's intent in enacting EMTALA was to prevent patient dumping — the turning away or transfer of poor or uninsured persons from emergency treatment because of their inability to pay. However, the language Congress ultimately chose to insert in the final version of the statute did not limit the statute's provisions to the poor or uninsured. Instead, Congress wrote EMTALA to permit "any individual who suffers personal harm as a direct result of a participating hospital's violation" to recover against the offending hospital. 42 U.S.C. § 1395dd(d)(2)(A). Congress's word choice was deliberate, as it was fully cognizant that many of the victims of inappropriate emergency treatment are neither indigent nor uninsured. *See Equal Access to Health Care: Patient Dumping: Hearing Before the Human Resources & Intergovernmental Relations Subcomm. of the House Comm. on Government Operations*, 100th Cong., 1st Sess. 40 (1987) (statement of Judith Waxman, managing attorney, the National Health Law Program, noting that while 37 million Americans have no health insurance coverage, an additional 50 million have inadequate coverage) (hereinafter "Subcomm. Hearing"). Regardless of the primary evil that Congress sought to cure, the language of the statute is controlling. *See, e.g., Brogan v. United States*, 118 S. Ct. 805, 809 (1998) ("[T]he reach of a statute often exceeds the precise evil to be eliminated."); *Oncale v. Sundowner Offshore Services, Inc.*, 118 S. Ct. 998, 1002 (1998) ("[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.").

In *Roberts*, the Sixth Circuit confirmed that its holding in *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990) required that a plaintiff prove that a hospital acted with an improper motive to recover under EMTALA. *Cleland*

involved a claim arising out of the medical screening requirement in 42 U.S.C. § 1395dd(a), and turned on the court's interpretation of the term "appropriate" as requiring an inquiry into the hospital's motives in administering the screening. The *Roberts* court went further and held that it could find "no rational reason to set forth differing standards when applying subsection (a) and (b) [the stabilization provision]," *Roberts*, 111 F.3d at 410 n.3, Jt. App. A12. Neither the text of the statute nor the legislative history provides any basis whatsoever for such a construction of either the medical screening or stabilization provision. Instead, these tools of construction make clear that courts should assess the statute's terms in accordance with medical criteria.

As an initial matter, the Sixth Circuit's interpretation of "appropriate" as containing the notion of motive is highly suspect. 42 U.S.C. § 1395dd(a) requires that "the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists." In this context, the term "appropriate" clearly relates to the purpose of the examination — i.e., that the examination must be appropriate to the determination of whether the patient has an emergency medical condition.

The term "appropriate" also appears in several other places in the statute. For example, § 1395dd(c)(2)(D) requires that "appropriate" life support measures be used if a transfer is effected. Even more important, the statute provides a detailed definition of "appropriate transfer," which makes no mention whatsoever of any anti-discrimination component of the phrase. *See* 42 U.S.C. § 1395dd(c)(2). Instead, the phrase is defined in terms of the "interest[s] of the health and safety of individuals transferred," focusing on the medical propriety of the transfer rather than the requirement of an improper animus propounded by the Sixth Circuit. As like words should be interpreted alike

within a single statute, *see* Sutherland, *Statutory Construction* § 47.16, the use of the term "appropriate" should not be construed to give rise to a requirement that a plaintiff show improper motive in order to prove a violation of EMTALA. *See also Atlantic Cleaners & Dyers v. United States*, 286 U.S. 427, 433 (1932) ("[T]here is a natural presumption that identical words used in different parts of the same act are intended to have the same meaning.").

The statute is equally clear that the stabilization provision does not require an inquiry into the hospital's motives. "[T]o stabilize" is defined in the statute as follows:

> with respect to an emergency medical condition . . . to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility . . .

42 U.S.C. § 1395dd(e)(3)(A). Similarly, "stabilized" means

> with respect to an emergency medical condition . . . that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . .

42 U.S.C. § 1395dd(e)(3)(B). Thus, the statute squarely indicates on its face that the "stability" of a patient is to be assessed in accordance with *medical* standards, without an inquiry into the motives of defendants.

Nonetheless, ignoring the plain text of the statute, the Sixth Circuit in both *Roberts* and *Cleland* decided that the terms

"appropriate" and "stabilize" contained within them the notion of motive. The court's effort to read a motive requirement into the statute is misguided: in interpreting these terms, the court blatantly ignored the primary tools of statutory construction — the text of the statute itself and its legislative history. There is no Committee Report or speech on the Senate floor or any other legislative source to support the assertion that "appropriate" or "stabilize" means "nondiscriminatory." In fact, during the 1987 hearings on implementation of the statute, testimony contrasted EMTALA's broad protection of "*all* beneficiaries of hospital services," with prior federal laws that protected only victims of discrimination or individuals who were able to prove that their dumping was motivated by economic factors. Subcomm. Hearing at 236 (statement of Richard Kusserow, HHS Inspector General).

All other federal Courts of Appeal which have considered whether a claim under EMTALA requires proof of an improper motive have looked at the plain wording of the statute and have concluded that it does not. *See Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1137-38 (8th Cir. 1996) (en banc) ("[W]e do not agree that evidence of a purpose to 'dump' a patient is required [to establish a violation of EMTALA]. Nor does the statute require any other particular motivation. . . . If a hospital fails to provide an appropriate medical screening examination, it is liable, no matter what the motivation was for this failure."); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 857 (4th Cir. 1994) ("[N]othing in the statute itself . . . requires proof of indigence, inability to pay, or any other improper motive on the part of a hospital as a prerequisite to recovery."); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 n.3 (D.C. Cir. 1991) ("We do not read subsection 1395dd(a) as referring in any way to the 'motives' with which an emergency room acts when it provides something less than its normal screening procedure."); and *Burditt v. U.S. Dep't of*

Health and Human Services, 934 F.2d 1362, 1373 (5th Cir. 1991) (the court refused to "invent a requirement found nowhere in the statute that an improper, or nonmedical, motive for transfer must be proved as an element of all EMTALA transfer violations. As written, EMTALA prevents patient dumping without such a requirement. . . . We refuse to alter the statutory scheme.").[3]

It is worth noting that EMTALA has been amended seven times since its enactment in 1986 — in 1986, 1987, 1988, 1989, 1990, 1994, and 1997[4] — yet the inclusion of an improper motive requirement has never been discussed, let alone adopted. If Congress believed that the *Summers*, *Power*, *Gatewood*, and *Burditt* decisions were contrary to the statute, it had ample opportunity to amend the statute to include an improper motive requirement. That Congress did no such thing in either the 1994

---

3. *Burditt*, like the instant case, involved the transfer of an unstabilized patient. However, the statutory provision at issue in *Burditt* was 42 U.S.C. § 1395dd(d)(1), which provides for the imposition of civil money penalties by the Secretary of Health and Human Services and applies only when a hospital is negligent in violating EMTALA. In the case before this Court, the relevant statutory provision contains no negligence requirement but simply allows "any individual" who suffers harm because of an EMTALA violation to bring a civil action. 42 U.S.C. § 1395dd(d)(2)(A). There is therefore even less of a basis for reading an improper motive requirement into the civil action provision of the statute.

4. *See* Act of Oct. 21, 1986, Pub. L. No. 99-509, tit. IX, § 9307(c)(4), 100 Stat. 1996; Act of Dec. 22, 1987, Pub. L. No. 100-203, tit. IV, § 4009(a), 101 Stat. 1330-56, 1330-57; Act of Oct. 13, 1988, Pub. L. No. 100-485, tit. VI, § 608(d)(18)(E), 102 Stat. 2419; Act of Dec. 19, 1989, Pub. L. No. 101-239, tit. VI, §§ 6003(g)(3)(D)(xiv), 6211, 103 Stat. 2154, 2245; Act of Nov. 5, 1990, Pub. L. No. 101-508, tit. IV, §§ 4008(b)(1)-(3)(A), 4207(a)(1)(A), (2), (3), (k)(3), 104 Stat. 1388-44, 1288-117, 1388-124; Act of Oct. 31, 1994, Pub. L. No. 103-432 tit. I, § 160(d)(4), (5)(A), 108 Stat. 4444; Act of Aug. 5, 1997, Pub. L. No. 105-33, tit. IV, § 4201, 111 Stat. 373.

or 1997 amendments to the statute confirms the statute's plain meaning. *See North Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 535 (1982) ("Where an 'agency's statutory construction has been fully brought to the attention of the public and the Congress, and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned.' ") (citations omitted).

B. Congress Was Aware of Analogous Federal and State Laws That Explicitly Require Proof Of Improper Intent And Deliberately Chose Not To Enact Such A Requirement In EMTALA.

Prior to the enactment of EMTALA, hospital emergency services were regulated both by the Hill-Burton Act, 42 U.S.C. §§ 291, *et seq.*, and by state laws.[5] Congress was aware of both of these sources of law when it drafted and later amended EMTALA. *See*, *e.g.*, Subcomm. Hearing at 2 (statement of Representative Weiss, noting that Hill-Burton Act requires that hospitals receiving funds "must provide emergency care to certain individuals regardless of ability to pay"); Karen I. Treiger,

---

5. At the time that Congress enacted EMTALA, twenty-two states had statutes or regulations governing the provision of emergency services. *See* Cal. Health and Safety Code §§ 1317, 17409, 1978; Colo. Rev. Stat. §§ 26-15-101-110; Fla. Stat. Ann. §§ 395.0143, 401.45(1); Ga. Code. Ann. §§ 31-8-42, 31-8-43, 31-8-46; Hawaii Rev. Stat. § 321-232(b); Ill. Ann. Stat. Ch. 111 ½, § 86; Ky. Rev. Stat. Ann. §§ 216B.400(1), 216B.990(3); La. Rev. Stat. Ann. §§ 2113.4(2)-2113.4(b); Mass. Gen. Laws Ann. § 70E(m)(e); Mich. Stat. Ann. §§ 14.15(20715), 14.15(20704(4)), 14.15(20703); Mo. Ann. Stat. § 205.989(1); N.J. Admin. Code tit. 8, § 8.43-B1; N.Y. Public Health Law §§ 2805-b, 2806(1); Oregon Admin. Reg. Ch. 333, § 23(15); Pa. Admin. Reg. § 117.1(a), (b); R.I. Gen. Laws § 23-17-26(a); S.C. Admin. Reg. 61-16 § 309; Tenn. Code Ann. §§ 68-69-301, 68-39-302, 68-39-511(12); Tex. Health & Safety Code Ann. § 4438; Utah Code Ann. §§ 26-8-8(1), 26-8-2(12); Wis. Stat. Ann. § 146.301; Wyo. Stat. Ann. § 35-2-115(a).

Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186, 1201-02 (1986) (describing how Congress referred to the Texas statute in drafting EMTALA). In fact, Congress enacted EMTALA, in part, because the Hill-Burton Act proved ineffective in deterring patient dumping. *See* S. Rep. No. 1285, 93rd Cong., 2d Sess. 61, *reprinted in* 1974 U.S.C.C.A.N. 7842, 7900 (concluding that the implementation of Hill-Burton by the Department of Health, Education and Welfare and state agencies has been a "sorry performance").

The Hill-Burton Act was enacted in 1946, and imposed certain community service obligations on all hospitals receiving Hill-Burton funds. The regulations implementing the Hill-Burton Act specifically provided that

> [a] facility may not deny emergency services to any person who resides . . . in the facility's service area *on the ground that the person is unable to pay for those services.*

42 C.F.R. § 124.603(b)(1) (emphasis added). The HHS Office of Civil Rights construed these regulations to require, as a prerequisite to establishing a violation, proof that the hospital's decision to deny emergency services was motivated by the patient's inability to pay or some other improper factor. *See, e.g., In re Margaret R. Pardee Memorial Hospital*, (Hendersonville, N.C.; HHS/OCR No. 04803173, decided Sept. 4, 1981) (no evidence supported complainant's allegations that emergency services had been denied because he was unable to pay). Given Congress's dissatisfaction with Hill-Burton, Congress deliberately chose not to adopt the restrictive language of the Hill-Burton regulation and, instead, enacted a statute that does not require proof of defendant's motive for denying emergency services.

Congress was also aware of laws in twenty-two states that regulate the provision of emergency care when it enacted EMTALA. *See* H.R. Rep. 241, 99th Cong., 1st Sess., pt. 3, at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 726-27 (noting ineffectiveness of state laws and need for additional federal sanctions). These statutes vary tremendously. Some state laws explicitly provide that a defendant violates the law only if he or she was motivated to deny proper care by the patient's indigence. *See, e.g.*, Hawaii Rev. Stat. § 321-232(b) (1997) (emergency medical services shall not be denied "on the basis of the ability of the person to pay therefor or because of lack of prepaid health care coverage or proof of such ability to pay for coverage"). Other state laws explicitly prohibit denial of emergency care based upon a variety of improper factors, including indigence. *See, e.g.*, Tex. Health & Safety Code Ann. § 311.022 (1998 Supp.) (emergency services shall not be denied "because a person cannot establish [his] ability to pay for the services or because of race, religion, or national ancestry"). Still other state laws, like EMTALA, contain no such limitations and instead require that emergency services be provided to all who need emergency care. *See, e.g.*, N.Y. Pub. Health Law § 2805-b (McKinney 1993) ("hospital shall admit any person who is in need of immediate hospitalization with all convenient speed"). Particularly in light of these alternative models for addressing patient dumping, Congress's deliberately chosen language in EMTALA should be given its plain meaning.

II.

IMPOSITION OF A REQUIREMENT THAT A PLAINTIFF PROVE THE MOTIVATION OF THE HEALTH CARE PROVIDER WOULD SUBSTANTIALLY WEAKEN EMTALA, CONTRAVENING CONGRESS'S INTENT TO PROVIDE AN EFFECTIVE MEANS OF ENFORCEMENT.

A. The Burden of Proving The Motivation Of The Hospital Would Be Prohibitively High And Would Undermine Effective Enforcement Of The Statute.

If imposed, the burden of proving discriminatory intent would deter aggrieved individuals from bringing their claims to court and would reduce the likelihood of success for any who might proceed. "[T]he most fundamental problem with the motive requirement," wrote the Fourth Circuit in *Power*, is the "proof predicament." *Power*, 42 F.3d at 858. Indeed,

> a requirement that the plaintiff prove discriminatory intent . . . is often a burden that is impossible to satisfy. "Intent, motive and purpose are elusive subjective concepts."

Metropolitan Hous. Dev. Corp. v. Village of Arlington Heights, 558 F.2d 1283, 1290 (7th Cir. 1977), *cert. denied*, 434 U.S. 1025 (1978) (quoting *Hawkins v. Town of Shaw*, 461 F.2d 1171, 1172 (5th Cir. 1972) (en banc) (per curiam)). Imposition of this onerous evidentiary burden in EMTALA cases would thwart the purpose of the statute — i.e., the Congressional aim of ensuring access to emergency care for those in need of emergency services and for women in labor. Were such a principle to be adopted, the focus of efforts to recover under EMTALA would necessarily be on the state of mind of treatment providers, rather than upon the objective assessment of how the plaintiff was treated.

B. The Added Burden Of Proof Would Endanger The Lives Of Those In Need Of Emergency Care.

The imposition of an intent requirement would not only undermine the strength of the statute but would also endanger the lives of those in need of emergency care. By encumbering patients, many of them poor or working class, with an additional burden of proof, this requirement would dilute the deterrent effect of the statute.

As the House Committee on Government Operations recognized, "patient dumping has serious medical implications and can result in denial of necessary emergency care and even death." Equal Access Rep. at 5. Patients who are inappropriately transferred risk delays in emergency treatment, life threatening complications, and a higher mortality rate. *See id.* at 6. *See also* Subcomm. Hearing at 157 (statement of David A. Ansell, M.D., regarding the results of a study of transfers in Cook County, Illinois); Robert L. Schiff, *et al.*, *Transfers to a Public Hospital*, 314 New Eng. J. Med. 552, 555-56 (1986); David U. Himmelstein, *et al.*, *Patient Transfers: Medical Practice as Social Triage*, 74 Am. J. Public Health 494, 496 (1984).

Testimony before Congress in 1988 included striking examples of the harms caused by patient dumping. *See*, *e.g.*, Subcomm. Hearing at 42-43. Sadly there continues to be no shortage of such examples, as evidenced by the egregious nature of a number of 1995-96 EMTALA violations:

- A twenty-eight year old woman went to an emergency room complaining of severe abdominal pain. A pregnancy test was administered and came back positive, but the patient was discharged while continuing to suffer from the abdominal pain. She received no treatment for the pain, and was

readmitted three days later in shock with a ruptured ectopic pregnancy. *See* Public Citizen Research Group, *Hospital Violations of the Emergency Medical Treatment and Active Labor Act: A Detailed Look at "Patient Dumping,"* app. A-17 (Dec. 1997).

- An eleven month old child was brought to an emergency room by his mother. The child needed follow-up treatment for viral gastroenteritis and bilateral ototis media. The child's lab results indicated the child's condition was worsening. The child needed intravenous treatment, but emergency room personnel were unable to achieve proper placement. They failed to call the hospital's on-call physicians, and instead had the child transferred before he was stabilized. The child suffered cardiopulmonary arrest soon after arriving at the other hospital. *Id.* at A-7.

- In Massachusetts, a two-year old child who was suffering from a 103.2 degree fever, vomiting, and diarrhea was brought to the emergency room by her mother. The emergency room conducted no medical screening exam, and instead referred the patient to a private physician. Approximately seven hours after first going to the emergency room, the child had to be transported back in an ambulance. She was unresponsive upon arrival, and died soon after. *Id.* at A-12.

The dangers of dumping are also illustrated in the case presently before this Court.

The impact of the additional hurdle to securing EMTALA protection will be felt most severely by the poor and uninsured — those most at risk of being turned away at the hospital emergency room and those whom Congress intended EMTALA to protect. This group includes the more than 41.7 million Americans without health insurance coverage. *See* Bureau of the Census, Current Population Reports, Series P60-199, *Health Insurance Coverage: 1996* (1997).

As women's rights organizations, *amici* are particularly concerned about women's health, and the denial of emergency room care clearly jeopardizes the health of poor and uninsured women. Currently women represent over sixty-two percent of adult Americans living in poverty. *See* Bureau of the Census, Current Population Reports, Series P60-198, *Poverty in the United States: 1996* tbl. 2 (1997). Like petitioner here, forty-five percent of Americans without health insurance are women. *See* The Urban Institute, *State-Level Datebook on Health Care Access and Financing* (3d ed. 1998).

In contrast to men, women are more likely to have a publicly-funded source of insurance, such as Medicaid or Medicare — eleven percent of women ages eighteen to sixty-four are covered through the public sector whereas only seven percent of men receive public insurance. *See* Institute for Women's Policy Research, Research in Brief, *Women's Access to Health Insurance* (1996). Women are more likely than men to work in part-time jobs — sixty-eight percent of the part-time workforce are women. *See* Bureau of Labor Statistics, U.S. Department of Labor, *Geographic Profile of Employment and Unemployment 1996* tbl. 2 (1998). The number of hours worked per week is directly related to the likelihood that workers receive health insurance coverage through their employers; thus, women are less likely to have employer-sponsored insurance. *See* Institute for Women's Policy Research, *supra.*

Moreover, changes in welfare policies across the country are leading to reductions in Medicaid coverage. Between 1995-96, when states began changing their welfare policies and reducing their welfare caseloads using federal waivers, overall Medicaid enrollment dropped for the first time in a decade. *See* Marilyn Ellwood and Leighton Ku, *Welfare and Immigration Reforms: Unintended Side Effects for Medicaid*, 17 Health Affairs 137, 143 (May/June 1998). Since 1996 and the adoption of the new federal welfare law, welfare caseloads have dropped even more sharply than during the 1995-96 period. Complete national Medicaid data are not available, but preliminary reports indicate that the decline in Medicaid enrollment, especially among adults, will continue. *See id.* at 143-45. And it does not appear that most families leaving welfare and Medicaid are obtaining private health insurance. The number and percentage of uninsured Americans rose as Medicaid enrollment dropped. *See id.* at 145. Furthermore, the prospects for poor women obtaining coverage are not good; a recent study found that three years after leaving Aid to Families with Dependent Children (AFDC), thirty-eight percent of women had private insurance, seventeen percent had Medicaid, and forty-five percent were uninsured. *See id.* at 150.

Even when poor women do have health insurance coverage, such insurance is not a shield to the dangers of patient dumping. Poor women, even when insured, remain at risk of being improperly denied medical care. In a study conducted before the enactment of EMTALA, researchers found that forty-six percent of the patients who were dumped were receiving public aid (including Medicaid) and three percent were insured through Medicare. *See* Schiff *et al.*, *supra*, at 553.

Women are particularly vulnerable to dumping when they face the "emergency" of giving birth. *See, e.g.*, *Burditt*, 934 F.2d 1362 (pregnant woman in active labor transferred in

unstable condition because she was uninsured). *See also* Lauren Dame & Sidney Wolfe, Public Citizen Health Research Group, *Hospital Violations of the Emergency Medical Treatment and Active Labor Act: A Detailed Look at "Patient Dumping,"* app. 1 (Dec. 1997) (patient in labor in Little Rock, Arkansas was transferred, unaccompanied by persons trained for medical emergencies or in the delivery of a baby; patient in Dardanelle, Arkansas who was experiencing contractions every four to five minutes was transferred without qualified personnel or transportation equipment). The language of EMTALA specifically includes labor within the definition of "emergency condition" in order to protect women in labor from improper screening and transfer. *See* 42 U.S.C. § 1395dd(e)(1)(B). This explicit consideration of women in labor reveals Congress's intention to establish strong protections for poor pregnant women against being "dumped" during childbirth. If pregnant patients must prove discriminatory intent in order to prevail on an EMTALA claim, the force of this safeguard for poor women and newborns will be severely weakened.

The problem of patient dumping also disproportionately affects minorities. More than twenty-eight percent of African-Americans and twenty-nine percent of Hispanics live below the poverty level. *See Poverty in the United States: 1996*, *supra*, tbl. 2. Twenty-one percent of African-Americans and thirty-three percent of Hispanics are uninsured, compared to fourteen percent of whites. *See* Bureau of the Census, *Statistical Abstract of the United States: 1997*, at tbl. 171. One survey found that eighty-nine percent of the improper transfers studied were of African-American or Hispanic patients. *See* Schiff *et al.*, *supra*, at 553.

Patients falling into more than one of these categories face even greater risk. For example, the loss of EMTALA protection for pregnant women of color threatens to exacerbate the already

tragic maternal and neonatal mortality rate among women of color. *See, e.g., Burditt*, 934 F.2d 1362 (Uninsured Hispanic woman transferred while in active labor). In 1992, the maternal mortality rate for women of color was 18.2 per 100,000 live births compared to 5.0 for white women. The 1994 neonatal death rate for infants of color was 8.6 per 1,000 live births compared to 4.2 for white infants. *See Statistical Abstract of the United States: 1997, supra*, tbl. 123.

Finally, patient dumping among the insured is becoming a larger problem as hospitals contract with Health Maintenance Organizations ("HMOs") to provide services to their members. Patients who are taken to hospitals that do not have contracts with their HMO are increasingly directed to other hospitals, improperly transferred in unstable conditions, or provided with care that they must later pay for in full. *See* Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 Health Matrix 3 (1998). In light of the fact that eighty-one percent of insured Americans are covered by managed care plans, *see* Public Citizen Research Group Report, *supra*, at 10 n.15, the problem of patient dumping is likely to affect more and more Americans — even those with insurance.

No matter what the cause or motivation, the denial of emergency treatment and the inappropriate transfer of patients represent serious barriers to health care access. With the passage of EMTALA, Congress took forceful steps to address these barriers. The imposition of an intent requirement would substantially weaken the statutory scheme established by Congress and would place the lives of those in need of emergency care at greater risk.

CONCLUSION

For the foregoing reasons, the judgment of the Sixth Circuit should be reversed.[6]

Respectfully submitted,

MARTHA F. DAVIS
Counsel of Record
NOW LEGAL DEFENSE AND
EDUCATION FUND
99 Hudson Street
12th Floor
New York, New York 10013
(212) 925-6635

M. ELAINE JOHNSTON
200 Haven Avenue
New York, New York 10033
(212) 543-2776

Attorneys for Amici Curiae

---

6. Attorneys for *amici* would like to acknowledge the assistance of Thomas M. Gorman and Maya Grosz in the preparation of this brief.

Supreme Court, U.S.
FILED
SEP 22 1998
OFFICE OF THE CLERK

No. 97-53

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

JANE M. ROBERTS,
Guardian for Wanda Y. Johnson,
Petitioner,

v.

GALEN OF VIRGINIA, INC., Formerly d/b/a
Humana Hospital - University of Louisville,
Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF SURGEONS, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, CONGRESS OF NEUROLOGICAL SURGEONS, AND AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AS *AMICI CURIAE* SUPPORTING RESPONDENT

Thomas W. Merrill*
Northwestern University School of Law
357 East Chicago Avenue
Chicago, Illinois 60611
(312) 503-8074

(additional counsel listed on inside cover)

September 22, 1998 *Counsel of Record

BEST AVAILABLE COPY

(additional counsel listed from outside cover)

Of Counsel
Fredric J. Entin
James A. Henderson
American Hospital Association
One North Franklin
Chicago, Illinois 60606

Michael L. Ile
Leonard A. Nelson
American Medical Association
515 North State Street
Chicago, Illinois 60610

Katherine O. Orrico
American Association of Neurological Surgeons
Congress of Neurological Surgeons
725 15th Street, N.W.
Suite 800
Washington, D.C. 20005

Robert M. Portman
Jenner & Block
601 13th Street, N.W.
Washington, D.C. 20005
Counsel for American College of Surgeons and American College of Emergency Physicians

BEST AVAILABLE COPY

QUESTIONS PRESENTED

Amici believe that, in addition to the question presented by petitioner, this case also presents the following questions: Did respondent hospital violate the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, by discharging an individual when (a) the discharge occurred after the individual had been admitted to a non-emergency department of the hospital for two months of treatment and (b) the individual's treating physicians did not believe that she had an emergency medical condition?

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

TABLE OF AUTHORITIES iv

INTEREST OF *AMICI* 1

STATEMENT 3

SUMMARY OF ARGUMENT 4

ARGUMENT 6

I. EMTALA CREATES A NARROW SET OF INTEGRATED DUTIES DESIGNED TO CLOSE A GAP IN STATE LAW THAT PERMITTED SOME HOSPITAL EMERGENCY ROOMS TO "DUMP" UNINSURED PATIENTS 6

A. EMTALA's Narrow Gap-Filling Purpose 6

B. EMTALA's Limited Federal Duties . . 11

C. Petitioner And The Solicitor General Interpret EMTALA To Create A Broad Form Of Federal Malpractice Liability 16

Page

II. THE SIXTH CIRCUIT CORRECTLY CONCLUDED THAT EMTALA DOES NOT PERMIT THE IMPOSITION OF LIABILITY ON THE RESPONDENT HOSPITAL IN THIS CASE 20

A. EMTALA Imposes No Duties On Hospitals With Respect To Individuals Who Are Admitted To The Hospital For Treatment 22

B. EMTALA Imposes No Duty To Stabilize Unless The Responsible Physicians Believe The Individual Had An Emergency Medical Condition At The Time Of Transfer 27

CONCLUSION 30

TABLE OF AUTHORITIES

Cases: **Page**

Apex Hosiery Co. v. *Leader*, 310 U.S. 469 (1940) 11

Baber v. *Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992) 12, 29

Birmingham Baptist Hospital v. *Crews*, 229 Ala. 398, 157 So. 224 (1934) 7

Brooks v. *Maryland Gen. Hosp., Inc.*, 996 F.2d 708 (4th Cir. 1993) 7

Bryan v. *Rectors and Visitors of University of Virginia*, 95 F.3d 349 (4th Cir. 1996) 8, 26, 27

Cleland v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) . . . 3, 4, 10, 15, 20, 29

Collins v. *DePaul Hospital*, 963 F.2d 303 (10th Cir. 1992) 26

Correa v. *Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996) 9, 13, 18

Eberhardt v. *City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) 9, 12, 29

Cases: **Page**

Gatewood v. *Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) 8, 10

Hamelin v. *Michigan*, 501 U.S. 957 (1991) 18

Holcomb v. *Monahan*, 30 F.3d 116 (11th Cir. 1994) 10, 29

Isbrandtsen Co. v. Johnson, 343 U.S. 779 (1952). 11

Jones v. *Garcia*, 936 F. Supp. 929 (M.D. Fla. 1996) 18

Marshall v. *East Carroll Parish Hospital Service District*, 134 F.3d 319 (5th Cir. 1998) 9, 13, 29

Matter of Baby K, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 513 U.S. 825 (1994) 18

Napier v. *Greenzweig*, 256 F.196 (2d Cir. 1919) . 7

New State Ice Co. v. *Liebman*, 285 U.S. 262 (1932) 19

Power v. *Arlington Hospital Association*, 42 F.3d 851 (4th Cir. 1994) 10

Public Citizen v. *United States Department of Justice*, 491 U.S. 440 (1989) 21

Rector, Holy Trinity Church v. *United States*, 143 U.S. 457 (1892) 21

Cases: ***Page***

Repp v. *Anadarko Municipal Hospital*, 43 F.3d 519 (10th Cir. 1994) 10, 12

Schenck v. *Pro-Choice Network of Western New York*, 117 S. Ct. 855 (1997) 21

Smith v. *Richmond Memorial Hospital*, 243 Va. 445, 416 S.E.2d 689 (1992) 26

Summers v. *Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) 9, 13, 29

Thorton v. *Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990) 26

United States v. Bass, 404 U.S. 336 (1971) . . . 10

United States v. *Texas*, 507 U.S. 529 (1993) . . 11

Urban by and Through Urban v. *King*, 43 F.3d 523 (10th Cir. 1994) 29

Vickers v. *Nash General Hospital, Inc.*, 78 F.3d 139 (4th Cir. 1996) 10, 13, 29

Statutes:

Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd . . . . . *passim*

Statutes: ***Page:***

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986) 6

42 U.S.C. § 1395xx(a) 23

42 U.S.C. § 1395ww(a) 23

Publications:

61 Am. Jr. 2d, *Physicians, Surgeons, and Other Healers* (1981) 8

John F. Bales, *Medical Malpractice Developments*, 700 PLI/Comm 563 (1994) 19

Ballantine's Law Dictionary (3d ed. 1969) 28

W. Page Keeton, et al., Prosser and Keeton on the Law of Torts (5th ed. 1984) 7, 8

Random House Dictionary of English Language (2d ed. 1987) 28

Restatement 2d of Torts (1965) 8

Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 Hous. L. Rev. 21 (1989) . 8

Publications: ***Page:***

Webster's Third New International Dictionary (1993) 28

Miscellaneous:

131 Cong. Rec. S 13892 (1985) 8

131 Cong. Rec. S 13903 (1985) 7

H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), *reprinted in* 1986 U.S. Code Cong. & Admin. News 579, 605. 7

No. 97-53

In the
Supreme Court of the United States
October Term, 1997

JANE M. ROBERTS,
Guardian for Wanda Y. Johnson,

Petitioner,

v.

GALEN OF VIRGINIA, INC., Formerly d/b/a Humana Hospital - University of Louisville,

Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF SURGEONS, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, CONGRESS OF NEUROLOGICAL SURGEONS, AND AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AS *AMICI CURIAE* SUPPORTING RESPONDENT

INTEREST OF *AMICI* [1]

The American Hospital Association (AHA) is the largest national membership organization of hospitals in this country. Its membership includes approximately 5000 hospitals, health systems, networks, and other providers of care. The American Medical Association (AMA) is the largest national membership organization of physicians in this country. Its members include approximately 300,000 physicians, including many who provide emergency medical services in hospital emergency rooms. The American College of Surgeons (ACS) is the largest national membership organization comprised exclusively of surgeons in this country. Its members include approximately 56,000 surgeons, including many who provide emergency medical services in hospital emergency rooms. The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) represent over 4,500 practicing neurosurgeons in the United States. Their members are called upon to provide emergency medical services for a wide variety of conditions. The American College of Emergency Physicians (ACEP) is a professional and educational society of more than 19,600 emergency physicians who practice in emergency medicine departments across the country.

---

[1] This brief is submitted with the consent of counsel for all parties. No person or entity, other than the *amici*, made any monetary contribution to the preparation of this brief. Counsel of record is counsel to the Chicago office of the law firm of Sidley & Austin. Lawyers in that firm assisted in the preparation of this brief. After counsel of record was retained by the *amici*, Mr. Carter G. Phillips, a partner in the Washington D.C. office of Sidley & Austin, was retained by respondent to serve as its counsel in this Court. However, neither Mr. Phillips nor anyone assisting him in the preparation of respondent's brief authored, in whole or in part, this brief.

The Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, requires that every covered hospital emergency department provide an appropriate medical screening examination to any individual who seeks assistance at the emergency room. 42 U.S.C. § 1395dd(a). It further requires that hospitals take appropriate steps to assure that any transfer of an individual from an emergency room will not further impair the individual's condition. 42 U.S.C. § 1395dd(b). In enacting these limited but important federal duties, Congress sought to eliminate the practice of "dumping" uninsured patients who come to emergency rooms seeking assistance. The AHA, AMA, ACS, AANS, CNS, and ACEP fully support this statutory objective.

While supporting the purpose of EMTALA, *amici* also share the concern, voiced by virtually every court of appeals, *see infra* p. 9 n.5, that the Act not become a substitute for state medical malpractice liability. EMTALA contains language, such as the requirement that individuals be "stabilized" before they are transferred, that, if taken out of context and given an expansive interpretation, could create a federal cause of action that would duplicate the liability that already exists under state law. Construing EMTALA in this fashion could lead to a federalization of standards of medical care, would create widespread opportunities for forum shopping, and would undermine state efforts to reform their tort systems. *Amici* urge that this Court construe EMTALA in keeping with the intent of Congress to establish limited federal duties to screen and stabilize individuals who come to hospital emergency rooms seeking assistance -- and not to create a general federal cause of action for malpractice. Accordingly, *amici* support affirmance of the decision below.

STATEMENT

Wanda Johnson, petitioner's ward, was severely injured when she was struck by a truck while walking home from work. Ms. Johnson was not denied an appropriate medical screening examination at respondent's emergency room. Nor was she transferred from the emergency room to another hospital without first being stabilized. To the contrary, she was admitted to the University of Louisville Hospital for extensive and prolonged treatment. Petn. A27.[2]

Johnson was discharged from the hospital only after her physicians concluded that her condition had been stabilized and only after the hospital staff had identified a skilled nursing facility which would provide her appropriate rehabilitative care. J.A. 31-33, 116. The decision to discharge Johnson was regarded as medically appropriate by all of her treating physicians. J.A. 131, 133, 135. They testified, without contradiction, that financial considerations did not play a role in their discharge decision. J.A. 131, 133, 135.

Both of the lower courts recognized that imposition of EMTALA liability is not warranted on these facts. The Sixth Circuit observed that "EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence." Petn. A10 (citation omitted). In order to keep EMTALA within its proper bounds, the court reaffirmed its decision in *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir.

---

[2] The Appendix to the Petition for Certiorari is cited as "Petn. A___." The Joint Appendix is cited as "J.A. ___."

1990), which it characterized as requiring EMTALA claimants to show some type of "improper motivation" on the part of the hospital before they may recover damages. *Id.* After reviewing the record, the court found there was no evidence that "Humana acted with an improper motive when it discharged Johnson." *Id.* A14.

SUMMARY OF ARGUMENT

EMTALA is a narrow statute designed to remedy a very specific problem, *i.e.*, the practice of a small number of hospitals in the 1980s of "dumping" individuals who presented at the emergency room with an emergency condition but no ability to pay. Although Congress created a private right of action for individuals directly injured by a hospital's violation of the federal duties created by EMTALA, there is no indication in the language of the statute or its history that Congress intended to create a general federal cause of action for malpractice in the emergency room setting. Every court of appeals that has considered the Act has recognized the importance of assuring that EMTALA's narrow federal duties do not mushroom into a substitute for state tort liability.

The Sixth Circuit's decision in *Cleland*, *supra*, interpreted EMTALA as requiring proof of a non-medical motive, other than mere negligence, as a condition of recovering damages in a private action. This implied limitation on EMTALA liability confines the statute to the perceived evil that gave rise to its enactment: It imposes liability on hospitals and physicians who dump individuals from emergency rooms because of their inability to pay or other non-medical reasons -- while avoiding invocation of EMTALA as a substitute for state malpractice law.

While *amici* support a narrowing construction of EMTALA, there is no need in this case to invoke the Sixth Circuit's implied mental state requirement in order to reach the right result and effectuate the intent of Congress. In addition to the improper motive test relied upon by the Sixth Circuit, two alternative grounds fully support the judgment below. These alternative grounds are solidly supported by the language and structure of EMTALA, and they have been endorsed by the courts of appeals. This Court should address these two alternative grounds and affirm the judgment of the Sixth Circuit.

First, the language and structure of the Act reveal that EMTALA's duties apply only where an individual comes to a hospital emergency room with an emergency medical condition, and the hospital either refuses to provide an appropriate medical screening examination or transfers the individual without first stabilizing the emergency condition. EMTALA provides no basis for extending these duties to individuals who come to an emergency room and then are *admitted* to the hospital for treatment. Once an individual is admitted for treatment, a hospital-patient relationship is established, and the quality of subsequent care is governed by well-established state law tort duties. In this case, Wanda Johnson was admitted to the respondent hospital, and received treatment for two full months. At that point, any controversy over whether she was properly discharged is governed by state law, not by the limited federal duties of EMTALA. If the hospital was negligent in discharging Johnson, she has a remedy under state tort law.

Second, the plain language of EMTALA indicates that a hospital's duties regarding stabilization before transfer apply only when an individual comes to the hospital "and the

hospital *determines* that the individual has an emergency medical condition." 42 U.S.C. § 1395dd(b) (emphasis added). As the lower courts have unanimously held, a hospital "determines" that an emergency medical conditions exists only if it has actual knowledge of such a condition. The evidence in this case is uncontradicted that Johnson's treating physicians did not believe that she had an emergency medical condition when they discharged her. Therefore, judgment should have been entered for the respondent hospital on the ground that the condition precedent to EMTALA liability for failing to "stabilize" an individual before transfer -- a determination that Johnson had an emergency medical condition -- had not been satisfied.

ARGUMENT

I. EMTALA CREATES A NARROW SET OF INTEGRATED DUTIES DESIGNED TO CLOSE A GAP IN STATE LAW THAT PERMITTED SOME HOSPITAL EMERGENCY ROOMS TO "DUMP" UNINSURED PATIENTS

A. EMTALA's Narrow Gap-Filling Purpose

Congress enacted EMTALA in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986). The Act was passed in response to widespread publicity about episodes in which certain hospitals had apparently "dumped" individuals who came to their emergency rooms seeking treatment. In other words, individuals were reportedly turned away from the emergency room without being examined, or were shunted from private hospital emergency rooms to public hospitals without any examination or treatment, because they

were poor and lacked health insurance. *See* H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605; 131 Cong. Rec. S13,903-05 (1985) (remarks of Sens. Durenberger, Kennedy, Dole, Heinz and Proxmire).

Hospitals which engaged in emergency-room "dumping" were able to do so because, under the common law rule, physicians and hospitals have no affirmative legal duty to provide medical care to individuals with whom they have no prior relationship.[3] In general, the common law limits the liability of physicians and hospitals to those individuals with whom they have agreed to provide treatment, thereby establishing a physician-patient or hospital-patient relationship.[4] *See, e.g.*, *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) ("[u]nder traditional state tort law, hospitals are under no legal duty to provide [emergency care to all]"); *Birmingham Baptist Hospital v. Crews*, 229 Ala. 398, 157 So. 224 (1934) (private hospital "owes the public no duty to accept any patient not desired by it"). By refusing to examine an individual in an emergency room or by shunting an individual off to another institution, the hospital avoided creating any hospital-patient relationship under state common law. Hence, it incurred no liability

---

[3] The common law rule is based on a well-established principle of tort law that no one has a duty to protect any other person, unless a relationship exists between those individuals establishing a duty to act. *See* W. Page Keeton et al., Prosser and Keaton on The Law of Torts § 53, § 56 (5th ed. 1984).

[4] The agreement can either be a contract for which consideration is given or it can be a voluntary undertaking to provide care without charge. *See, e.g., Napier v. Greenzweig*, 256 F.196 (2d Cir. 1919). In either case, however, an affirmative agreement to treat is required before common-law duties attach to either the physician or the hospital.

under that law if the individual suffered injury because of the delay in treatment.

This gap in the common law is a narrow one. Once a physician-patient or hospital-patient relationship is established, *i.e.*, once the physician or hospital agrees to examine or treat an individual, then the law imposes a variety of duties. These include the duty of reasonable care, the duty not to provide unwanted medical treatment, and the duty not to abandon a patient after a physician-patient or hospital-patient relationship has been established. *See Bryan v. Rectors and Visitors of University of Virginia*, 95 F.3d 349, 351-52 (4th Cir. 1996); Restatement 2d of Torts § 323 (1965); Keeton, *supra*, at § 18, § 32, § 56; 61 Am. Jr. 2d, *Physicians, Surgeons, and Other Healers*, § 234, § 238 (1981). These common law duties have long played a critical role in regulating physician and hospital conduct toward patients in all States.

By 1986, a number of States had moved to close the gap that permitted emergency rooms to refuse any examination or treatment to particular individuals. *See* Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 Hous. L. Rev. 21, 53-57 (1989) (discussing state efforts to prohibit "patient dumping"). But Congress was aware that these reform efforts were far from complete. *See* 131 Cong. Rec. S.13892 (1985) (Sen. Kennedy) ("Some states have laws which ensure that no emergency patient is denied emergency care because of inability to pay. But 28 states have no such law."). EMTALA was designed to create a uniform rule, applicable to all hospitals that receive federal Medicare funding, that would close that gap once and for all on a national basis. *See Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037,

1041 (D.C. Cir. 1991) (EMTALA's purpose is "to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat").

Given the narrow remedial objective of EMTALA, it is clear that Congress did not intend to create a parallel system of federal liability that would be superimposed on top of the state common law duties that have long applied to established physician-patient and hospital-patient relationships. EMTALA expressly states that its provisions "do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). And the statute borrows from state liability law in defining the remedies available to individuals who may bring a civil action for personal harm suffered as a direct result of a hospital's violation of the Act. *Id.* § 1395dd(d)(2)(A). Congress was clearly legislating interstitially, against the backdrop of well-established state liability law, and without any design of duplicating that law or interfering with its future development.

Every court of appeals that has considered EMTALA has recognized that the Act was not intended to create "a general federal cause of action for medical malpractice in emergency rooms." *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc).[5]

---

[5] *Marshall v. East Carroll Parish Hospital Service District*, 134 F.3d 319, 322 (5th Cir. 1998) (EMTALA "was not intended to be used as a federal malpractice statute"); *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996) ("EMTALA does not create a cause of action for medical malpractice"); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("[t]he statutory language of the

(continued...)

As Chief Judge Richard Arnold of the Eighth Circuit has explained:

> The courts have construed the statute in this rather conservative fashion, we suppose, out of sensitivity to policies of federalism. Congress can of course, within constitutional limits, federalize anything it wants to. Whether it chooses to do so is a matter of policy for it to decide, not us. But in construing statutes that are less than explicit, the courts will not assume a purpose to create a vast new realm of federal law, creating a federal remedy for injuries that state tort law already addresses. If Congress wishes to take such a far-reaching step, we expect it to say so clearly.

Id. (citing *United States v. Bass*, 404 U.S. 336, 349 (1971)).[6]

---

[5] (...continued)
EMTALA clearly declines to impose on hospitals a national standard of care"); *Power v. Arlington Hospital Association*, 42 F.3d 851, 856 (4th Cir. 1994) ("EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence") (citations omitted); *Repp v. Anadarko Municipal Hospital*, 43 F.3d 519, 522 (10th Cir. 1994) (EMTALA "'is neither a malpractice nor a negligence statute'") (citation omitted); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) (EMTALA "is not designed to redress a negligent diagnosis by the hospital; no federal malpractice claims are created"); *Gatewood*, *supra*, 933 F.2d at 1041 (EMTALA "is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law"); *Cleland*, supra, 917 F.2d at 272 (by its terms, EMTALA "precludes resort to a malpractice or other objective standard").

[6] The constructional principle invoked by Chief Judge Arnold is, of course, fully consistent with this Court's more general teachings. This Court has long observed that "[t]he maintenance in our federal system of a proper (continued...)

B. EMTALA's Limited Federal Duties

The strategy that Congress adopted for closing the gap in state law that permitted dumping of persons from emergency rooms is based on a carefully defined, three-tier system of federal legal duties. These duties are set forth in subparts (a), (b), and (c) of EMTALA. Petitioner and the Solicitor General would have this Court interpret the words of subpart (b) -- the provision most directly applicable in this case -- in isolation from the other two parts. But it is not possible to grasp the import of any one of the three tiers of obligation without considering how they work together. Cumulatively, these three subparts describe a single coherent set of duties that define how hospitals and physicians must respond to individuals who seek assistance in hospital emergency rooms. The Act does not purport to govern any other aspect of physician-patient or hospital-patient relationships.

Subpart (a) imposes a duty on every hospital that receives Medicare funds and has an emergency room to perform an "appropriate medical screening examination" on any individual who comes to the emergency room seeking an

---

[6] (...continued)
distribution between state and national governments of police authority and of remedies private and public for public wrongs is of far-reaching importance. An intention to disturb the balance is not lightly to be imputed to Congress." *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 513 (1940). A corollary doctrine is that federal statutes should not be construed so as to alter the common law unless Congress has carefully considered and fully intended such a result. *See, e.g., United States v. Texas*, 507 U.S. 529, 534 (1993) ("`[s]tatutes which invade the common law...are to be read with a presumption favoring the retention of long-established and familiar principles, except when a statutory purpose to the contrary is evident'") (quoting *Isbrandtsen Co. v. Johnson*, 343 U.S. 779, 783 (1952)).

examination or treatment for a medical condition.[7] Subpart (a) is by far the broadest of the duties prescribed by EMTALA. It applies to any individual who presents at a hospital emergency room -- regardless of what kind of medical problem the individual may have and regardless of whether the patient is a Medicare beneficiary. Thus, the hospital must perform an "appropriate medical screening" on a child with a bruised knee as well as an accident victim near death.

Although broad, the duty set forth in subpart (a) is also carefully circumscribed. First, it expressly applies only to "a hospital emergency department." It does not apply to physician offices, clinics, nursing homes, hospices, or departments of hospitals other than the emergency room. *See Baber v. Hospital Corp. of America*, 977 F.2d 872, 884 (4th Cir. 1992).

Second, the statute specifically qualifies the appropriate screening examination requirement by saying that it is to be one "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." Thus, EMTALA does not impose a uniform federal standard of screening on hospital emergency rooms.[8] EMTALA merely requires that

---

[7] The test of subpart (a) may be found at Petn. A55.

[8] *See Eberhardt*, *supra*, 62 F.3d at 1258 ("The statutory language of the EMTALA clearly declines to impose on hospitals a national standard of care in screening patients."); *Repp*, *supra*, 43 F.3d at 522 ("The phrase that modifies 'appropriate medical screening' reveals that the requisite standard, far from being uniform, varies with the particular conditions of each emergency room"); *Baber*, *supra*, 977 F.2d at 879-880 ("EMTALA does not

(continued...)

every hospital emergency room have some set of policies and procedures for screening individuals who present themselves and that these policies and procedures be applied uniformly to all individuals.[9] This "equal screening" construction of subpart (a) preserves the primary purpose of EMTALA — to prevent hospitals from refusing to examine indigent or uninsured individuals who come to emergency rooms — without federalizing standards of medical practice that traditionally have remained within the domain of the states.

Subpart (b) of EMTALA specifies the further duties that attach to a hospital if the "appropriate medical screening examination" mandated by subpart (a) results in a "determination" by the hospital that an "emergency medical condition exists."[10] The statute makes clear that such a determination is the condition precedent to any further EMTALA obligations beyond the initial emergency room

---

[8] (...continued)
impose on hospitals a national standard of care in screening patients.").

[9] *See Marshall*, *supra*, 134 F.3d at 322 ("an EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms"); *Summers*, *supra*, 91 F.3d at 1138 ("An inappropriate screening examination is one that has a disparate impact on the plaintiff"); *Vickers* v. *Nash General Hospital, Inc.*, 78 F.3d 139, 143 (4th Cir. 1996) ("EMTALA's requirement that individuals seeking emergency care receive an 'appropriate screening examination' obligates hospitals to 'apply uniform screening procedures to all individuals coming to the emergency room") (citation omitted); *Correa*, *supra*, 69 F.3d at 1192 ("hospital fulfills its statutory duty to screen patients in its emergency room if it provides . . . screening uniformly to all those who present substantially similar compiaints").

[10] The text of subpart (b) may be found at Petn. A55-56.

screening.[11] Subpart (a) concludes by saying that the medical screening is to be undertaken "to determine whether or not an emergency medical condition...exists." No other purpose of the screening is identified. And subpart (b) begins by conditioning its further duties with the clause: "If any individual...comes to a hospital *and the hospital determines that the individual has an emergency medical condition* . . ." (emphasis added). It follows that if a hospital determines that the individual has an emergency medical condition, the hospital is subject to further EMTALA duties under subparts (b) and (c). Conversely, if a hospital determines that the individual does not have an emergency medical condition, then EMTALA requires no further action on the part of the hospital.

Given the importance of the finding of an "emergency medical condition," it is not surprising that Congress provided a special definition of this concept. 42 U.S.C. § 1395dd(e)(1). That definition is narrowly drawn.[12] To qualify as an emergency medical condition, a condition must be one that manifests itself by "acute symptoms," including "severe pain," that a reasonable physician would conclude

---

[11] Although subpart (b), unlike subpart (a), is not expressly limited to determinations made in an emergency department, this subpart logically must also be limited to individuals who enter the hospital through the emergency room. This is because the determination of whether a medical emergency condition exists must be based on the appropriate medical screening examination, and the duty to provide such a screening attaches only to individuals who enter through an emergency room. The question whether subpart (b) applies to an individual who enters a hospital through some department other than the emergency room is not presented in this case, because it is undisputed that Johnson entered Humana through its emergency department.

[12] The text of subpart(e)(1) may be found at Petn. A62-63.

requires "immediate medical attention" to avoid "serious jeopardy" to an individual's health, "serious impairment" of bodily functioning, or "serious dysfunction" of any bodily organ or part.

If the hospital determines that the individual has an emergency medical condition and decides to transfer the individual, then subpart (b) specifies that the hospital must either provide for further examination or treatment to stabilize the medical condition, or must comply with the informed consent requirements of subpart (c). The first option requires the hospital, "within the staff and facilities available," to assure "within reasonable medical probability" that the individual's condition will not deteriorate during the transfer. Thus, the duty to stabilize during transfer, like the duty to provide an appropriate medical screening to all individuals who come to an emergency room, is defined in terms of the particular capabilities of the hospital. No uniform federal standard is imposed.

The Sixth Circuit in *Cleland, supra,* held that subpart (b), like subpart (a), imposes at most a duty of equal treatment on hospitals. *Cleland, supra,* 917 F.2d at 272. Under this construction, a plaintiff in order to maintain a stabilization claim must show that a hospital failed to follow its normal produces in treating a particular individual. Petitioner does not challenge the validity of this disparate treatment standard.

The second option given by subpart (b), which is spelled out in subpart (c), requires obtaining either the informed consent of the individual or a physician's certificate

that the benefits of the transfer outweigh the risks.[13] It also requires that the transfer and the facility to which the transfer occurs be "appropriate" given the individual's medical condition.[14] No issue regarding the meaning of subpart (c) is presented in this case.

C. Petitioner And The Solicitor General Interpret EMTALA To Create A Broad Form Of Federal Malpractice Liability

Petitioner and the Solicitor General effectively ignore the carefully integrated set of federal duties prescribed by subparts (a), (b), and (c) of EMTALA. Instead, they take the language of subpart (b) out of context and focus on the duty to "stabilize" individuals before they are transferred. They note that subpart (b), unlike subpart (a), is not by its terms expressly limited to emergency departments of hospitals. And they note that the term "transfer" is defined to include "discharge." 42 U.S.C. § 1395dd(e)(4). From this, they conclude that EMTALA imposes a wide-ranging duty on covered hospitals to "stabilize" every patient who enters the hospital with an emergency medical condition before such patient is discharged. Pet. Br. at 20-21; Solic. Gen. Br. at 7. Petitioner evidently believes that EMTALA holds hospitals strictly liable for failing to stabilize patients before they are discharged. Pet. Br. at 24-25. The Solicitor General recognizes that strict liability is inappropriate, Solic. Gen. at 17, but nevertheless would have the Court adopt a broad construction of EMTALA as imposing a federal duty of objective "reasonableness" applicable to any discharge

---

[13] The text of subpart(c)(1) may be found at Petn. A56.

[14] The text of subpart (c)(2) may be found at Petn. A58.

decision. *Id.* at 16-18.

These constructions of EMTALA are legally erroneous for the reasons set forth in Part II of this brief. More generally, the constructions urged by petitioner and the Solicitor General would make EMTALA the source of a sweeping federal cause of action for medical malpractice which would substantially duplicate state malpractice law. Any patient entering a hospital with an emergency medical condition who is admitted for treatment by the hospital would have a potential cause of action for damages under EMTALA on the ground that the patient's condition had not been adequately "stabilized."

The potential universe of individuals who could advance such claims would extend to every emergency patient who is admitted to the hospital. For example, a patient who entered a hospital with symptoms of a heart attack, was admitted to the hospital for treatment, and later suffered a second heart attack could bring an EMTALA action on the ground that he or she had not been properly "stabilized" after the first heart attack. There is no indication that Congress sought to establish such a broad cause of action overlapping existing state medical malpractice law. To the contrary, the creation of such a duplicate system of federal civil liability would give rise to a number of significant practical problems of great concern to *amici*.

First, the creation of a wide-ranging federal action for hospital malpractice could create pressure for a single uniform federal standard of reasonable care, usurping the traditional role of state common law in this area. This is not inevitable, since EMTALA limits the appropriate medical screening obligation to that "within the capability of the hospital's

emergency department," 42 U.S.C. § 1395dd(a), and limits the stabilization requirement to that "within the staff and facilities available at the hospital." *Id.* § 1395dd(b)(1)(A). This language should be read as excluding the development of uniform federal standards of medical care. But EMTALA's duties are federal duties, and courts applying these duties are likely to look to precedents from other federal courts or to regulations issued by the Secretary of Health and Human Services in resolving particular cases.[15] Over time, a certain pressure could arise tending toward the establishment of federal minimum standards, which would then evolve into a general uniform federal standard crowding out state standards. This would undermine all the advantages of allowing states to develop different standards that are responsive to different local values and conditions. *Cf. Hamelin v. Michigan*, 501 U.S. 957, 990 (1991) ("Diversity not only in policy, but in the means of implementing policy, is the very *raison d'etre* of our federal system.")

Second, the creation of a broad federal cause of action for hospital malpractice would give rise to widespread forum-shopping. This is because claimants would be able to assert, in addition to their federal EMTALA claim and without regard to the amount in controversy, state-law medical malpractice claims under supplemental jurisdiction. *See e.g.*, *Jones v. Garcia*, 936 F.Supp. 929 (M.D. Fla. 1996) (in action arising under EMTALA, district court exercised its supplemental jurisdiction over medical malpractice claims controlled by Florida law). A broad EMTALA cause of

---

[15] Some courts have suggested that EMTALA creates a minimum federal standard of appropriate screening, *see Correa*, *supra*, 69 F.3d at 1192, and have held that EMTALA imposes stabilization duties that exceed those required by state law, *see Matter of Baby K*, 16 F.3d 590, 596-97 (4th Cir. 1994), *cert. denied*, 513 U.S. 825 (1994).

action would therefore create expanded opportunities for claimants to choose which forum to hear their state malpractice cases -- federal court or state court. This expanded potential for forum shopping is unfair to defendants, and the increased skirmishing over preliminary jurisdictional issues would increase the costs of litigation.

Third, the creation of such a duplicate system of civil liability in federal courts would complicate efforts of state legislatures to make reforms in the common-law tort system. Many states, for example, have instituted certain types of alternative dispute resolution as a way of seeking to resolve claims involving physicians and hospitals. *See* John F. Bales, *Medical Malpractice Developments*, 700 PLI/Comm 563, 570-79 (1994) (discussing prevalence of state-mandated or encouraged use of alternative dispute resolution in medical malpractice litigation). Claimants might be able to evade such requirements by the expedient of filing a federal EMTALA claim, which is necessarily a civil action tried in court, and asserting their state claims under supplemental jurisdiction. Because *amici* support many of the efforts by state legislatures to reform the tort system, they strongly oppose any expansionist interpretation of EMTALA that could permit an end run around these experiments. *Cf. New State Ice Co. v. Liebman*, 285 U.S. 262, 311 (1932) (Brandeis J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

These practical concerns, of course, would not be sufficient to defeat EMTALA liability if Congress had created a general federal cause of action for hospital and physician

malpractice. In fact, however, it is quite clear that the structure, purpose, and language of the statute require the opposite conclusion.

II. THE SIXTH CIRCUIT CORRECTLY CONCLUDED THAT EMTALA DOES NOT PERMIT THE IMPOSITION OF LIABILITY ON THE RESPONDENT HOSPITAL IN THIS CASE

The judgment below is correct and should be affirmed. The lower courts dismissed petitioner's EMTALA action because there is no evidence that the physicians who signed Wanda Johnson's discharge papers were motivated by financial or other impermissible considerations. The Sixth Circuit's focus on the treating physicians' state of mind, first articulated in *Cleland, supra,* and then applied in the decision below, confines the scope of EMTALA liability to those situations where Congress intended that there would be liability. Under this approach, hospitals and physicians would not be subject to civil liability under EMTALA unless it could be shown that they had a non-medical reason, other than negligence, for failing to provide the same screening examinations and stabilization efforts to all individuals who come to a hospital emergency room seeking assistance. The court adopted this standard to ensure that EMTALA would not become a general substitute for state tort law. In contrast, both the strict liability construction urged by petitioner, and the objective reasonableness interpretation favored by the Solicitor General, would open the floodgates to broad federal liability that would substantially overlap traditional state tort remedies.

Amici urge this Court to affirm the Sixth Circuit's

improper motive test or some other limiting interpretation of the statute. The court of appeals' interpretation is clearly consistent with Congress' desire that EMTALA not be construed to create a federal cause of action for malpractice or a national standard of emergency medical care. Given the disparity between this clear legislative intent and the facially broad language of the statute, it is imperative the Court adopt some narrowing construction of the text of the statute, as it has done in similar circumstances. *See, e.g., Public Citizen* v. *United States Department of Justice*, 491 U.S. 440 (1989); *Rector* v. *Holy Trinity Church* v. *United States*, 143 U.S. 457 (1892). Indeed, virtually all of the courts of appeals that have interpreted EMTALA have applied some narrowing construction.

In any case, the Court need not embrace the improper motive standard in order to reach the right result in this case. There are two additional reasons, both fully supported by the language and structure of EMTALA -- and both well established in the decisions of the courts of appeals -- why judgment was properly entered for the respondent hospital. Specifically, *amici* request this Court to hold that (a) EMTALA does not apply once an individual has been admitted to the hospital and (b) EMTALA is not violated where the responsible physicians did not believe that the individual had an emergency medical condition at the time of transfer. Affirmance on either of these grounds would be fully supported by the law and the record in this case and would not expand the relief which has been granted. *See Schenck v. Pro-Choice Network of Western New York*, 117 S.Ct. 855, 870 n.12 (1997) (and cases cited). Moreover, like the Sixth Circuit's implied improper motive test, these grounds would confine the scope of EMTALA to the narrow gap-filling duties that Congress intended.

A. EMTALA Imposes No Duties On Hospitals With Respect To Individuals Who Are Admitted To The Hospital For Treatment

Petitioner alleges that respondent violated EMTALA by failing "to stabilize" Johnson prior to her discharge on July 24, 1992. This claim necessarily fails because the duty to stabilize applies only through the processing of the emergency condition that exists at the time the individual initially presents at the hospital. It does not apply to emergencies that arise after an individual has been admitted to the hospital for treatment. Once an individual is admitted, the hospital's duty to the individual is governed by state malpractice law, not by EMTALA.

The statutory language fully supports this conclusion. The subpart (b) duties are triggered when "any individual . . . *comes to a hospital* and the hospital determines that the individual has an emergency medical condition . . ." This language indicates that Congress was concerned with the initial presentation of the individual that occurs before a hospital-patient relationship is established.[16] It is also significant that EMTALA never uses the word "patient" to describe the persons protected by the federal duties created in

[16] The most likely reason that Congress referred to "hospitals" rather than "emergency departments" in subparts (b) and (c) is because subpart (a) requires that the determination whether an emergency medical condition exists be made "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." 42 U.S.C. § 1395dd(a). Thus, for example, an individual who comes to an emergency room may be taken to the radiology department for x-rays. Congress did not want to create a loophole that would permit the hospital to transfer individuals from the radiology department to another facility without assuring that they had first been stabilized.

subparts (a), (b), and (c). Instead, it refers throughout to these persons as "individuals." Other sections of the Medicare statutes refer to covered persons as "patients" in a context where a physician-patient or hospital-patient relationship exists. *See e.g.*, 42 U.S.C. § 1395xx(a); 42 U.S.C. § 1395ww(a). This too suggests that Congress was not legislating for persons who have been admitted to a hospital for treatment and who therefore have entered into a hospital-patient relationship.

Two important structural features of EMTALA support the conclusion that EMTALA applies only to individuals who have not been admitted by the hospital. First, as demonstrated in Part IB, *supra*, subpart (b)'s requirement that the hospital determine that an emergency medical condition exists is closely linked to subpart (a)'s requirement of an appropriate medical screening examination. And the requirement of an appropriate medical screening examination is expressly limited to individuals who seek assistance in a hospital "emergency department." It follows that the emergency medical condition to which subpart (b) refers must be a condition that was discovered through the initial screening conducted in the emergency room.

This means, at the very least, that the emergency medical condition that triggers duties with respect to transfer must be *the same* emergency condition that brought the individual to the hospital, not a condition that developed only later. That alone is enough to defeat any EMTALA liability in this case. Further, the linkage between subpart (a) and subpart (b) suggests that the latter subpart applies only to transfers that occur from the emergency room, or that occur immediately after the medical screening examination has been completed -- not transfers that occur after the individual has

been admitted for treatment.

Second, EMTALA imposes no federal duties on hospitals with respect to patients who are admitted for treatment. The additional duties imposed by EMTALA if the hospital determines that an individual has an emergency medical condition attach only if the hospital decides *to transfer* the patient to another facility. The failure to address the very common situation of an individual who presents at an emergency room and who is admitted to the hospital strongly suggests that Congress did not consider this a problem to be addressed by federal law.[17]

The fact that the duty to stabilize is limited to transfers does not appear immediately from the face of subpart (b), but emerges from the definitions. Subpart (b) provides that if a hospital determines that the individual has an emergency medical condition, it

> must provide either --
>
> **(A)** within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required *to stabilize* the medical condition, or

[17] EMTALA defines "transfer" to include "discharge." 42 U.S.C. § 1395dd(e)(4). But this does not expand the coverage of the statute beyond transfers that occur immediately after the determination in the emergency room that an individual has an "emergency medical condition." Congress was obviously concerned not only with how emergency rooms transport critically ill or injured patients to other facilities, but also with the possibility that such an individual would simply be discharged from the emergency room.

> **(B)** for transfer of the individual to another medical facility in accordance with subsection (c) of this section (emphasis added).

Standing alone, the first of these alternatives might be read as imposing some free-floating requirement "to stabilize" all individuals having emergency medical conditions in hospitals. But the Act contains specific definitions of the terms "stabilize" and "to stabilize," which are substantively identical.[18] Both definitions focus on the need to prevent deterioration of the individual's condition during a transfer. The hospital must assure, "within reasonable medical probability, that no material deterioration of the [emergency medical] condition is likely to result from or occur *during the transfer* of the individual from a facility" (emphasis added).

The reason that EMTALA does not address the case of the individual with an emergency medical condition who is admitted for treatment is that the decision to admit the individual creates a hospital-patient relationship. Once this relationship is formed, the quality of the care and treatment that the patient receives are fully governed by preexisting sources of state law, including malpractice law. Consequently, it was not necessary to legislate any new federal duties to cover this situation.[19]

[18] The definitions of the terms "stabilize" and "to stabilize" may be found at Petn. A63-64.

[19] EMTALA itself cannot be construed as imposing a hospital-patient relationship or a physician-patient relationship and hence triggering the full panoply of common-law duties. The common law requires a voluntary undertaking to treat by a physician or a hospital to create such a relationship. *See* p.1 & n.4 *supra*. Compliance with a narrow federal mandate does not

(continued...)

The understanding that EMTALA's stabilization requirement does not apply to an individual who has been admitted to the hospital for treatment as a patient has been endorsed by the only federal court of appeals squarely to address this question. *Bryan*, *supra*, 95 F.3d at 352.[20] There, an individual came to the hospital in an emergency condition and was admitted for treatment as a patient. After 12 days, the hospital entered a "do not resuscitate" order, allegedly against the wishes of the family. The patient died 8 days later. The family then sued under EMTALA, claiming that the failure to resuscitate constituted a breach of subpart (b)'s the duty "to stabilize" a patient with an emergency medical condition. The court rejected the claim, holding that EMTALA's stabilization requirement

---

[19] (...continued)
constitute a voluntary agreement to treat. Moreover, whether or not a hospital-patient relationship or a physician-patient relationship could be imposed by a properly drawn state or federal statute, EMTALA is not such a law. The duty to treat imposed by EMTALA is narrowly confined to determining whether an individual has an emergency medical condition and if so, to assuring that the individual is stabilized or has given consent before being transferred. Nothing in the language of EMTALA suggests that hospitals or physicians must go further, as the respondent hospital did in this case, and assume a general duty of care of individuals as patients.

[20] *See also Collins v. DePaul Hospital*, 963 F.2d 303 (10th Cir. 1992) (holding that no claim for inappropriate screening under subpart (a) of EMTALA could be brought where as a result of the examination the individual was admitted to the hospital for treatment as a patient). This interpretation has been rejected by one state court. *See Smith* v. *Richmond Memorial Hospital*, 243 Va. 445, 416 S.E.2d 689 (1992) (holding that EMTALA applies to any emergency condition that occurs in a hospital, even after the patient has been admitted). *Cf. Thorton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990) (holding that once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, even if the patient has been admitted to another department of the hospital).

> . . . was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context.

Id. at 352.

The holding of *Bryan* is supported by the language, the structure, and the purposes of EMTALA That holding is fully applicable to Johnson's circumstances. Indeed, Johnson was admitted and treated for two months -- a far longer period than the patient in *Bryan*. Under *Bryan*, therefore, any claim that Johnson had against the hospital based on an allegedly negligent or premature discharge should be based on state malpractice law or the tort of abandonment, *id.*, not EMTALA. For this reason, summary judgment was properly entered for respondent.

B. EMTALA Imposes No Duty To Stabilize Unless The Responsible Physicians Believe The Individual Had An Emergency Medical Condition At The Time Of Transfer

Respondent was also under no EMTALA duty "to stabilize" Johnson at the time of her discharge because its treating physicians did not believe that she had "an emergency medical condition" at that time. It is undisputed that Johnson had an emergency medical condition when she was brought to Humana after her accident. But her treating physicians

testified that when she was discharged after two months of treatment, they did not perceive her as having an emergency medical condition. That testimony was uncontradicted, and requires that summary judgment be entered for respondent.

As noted in Part IB, *supra*, the hospital's determination that an individual has an emergency medical condition is the condition precedent to concluding that the hospital is under any further EMTALA duty with respect to the transfer of an individual. If the hospital determines there is no emergency medical condition, then EMTALA imposes no duty beyond the appropriate medical screening required by subpart (a). Only if the hospital concludes the individual has an emergency medical condition does EMTALA require that the individual be stabilized before transfer or that the transfer take place within the requirements of subpart (c).

Moreover, the statute provides that these additional duties with respect to transfer apply only when an individual comes to a hospital "and the hospital *determines* that the individual has an emergency medical condition." 42 U.S.C. § 1395dd(b) (emphasis added). In order "to determine" that an emergency medical condition exists, the hospital -- or rather physicians practicing at the hospital -- must have actual knowledge that such a condition exists.[21]

The plain language of subpart (b) admits of no other interpretation on this point. Not surprisingly, therefore,

---

[21] To "determine" in this context means to "discover," *see* Webster's Third New International Dictionary 616 (1993), or to "ascertain," *see* The Random House Dictionary of the English Language 542 (2d ed. 1987); Ballantine's Law Dictionary 344 (3d ed. 1969). Either to discover or to ascertain that a particular conditions exists requires actual knowledge that the condition exists.

seven circuits have held that the hospital must have actual knowledge of the patient's emergency condition before the duty to stabilize attaches, and no circuit has held to the contrary.[22] As the Fourth Circuit explained in *Vickers, supra*, 78 F.3d at 145 (citations omitted) (emphasis in original):

> [A] stabilization claim exists when "the patient had an emergency condition" and "the hospital *actually knew* of *that* condition." The Act does not hold hospitals accountable for failing to stabilize conditions of which they are not aware, or even conditions of which they should have been aware. EMTALA would otherwise become coextensive with malpractice claims for negligent treatment.[23]

It would be very difficult to argue that Wanda Johnson had an "emergency medical condition" prior to her discharge on July 24, 1992. She did not manifest any "acute symptoms...(including severe pain)." 42 U.S.C. § 1395dd(e)(1). Her medically significant symptoms were a low grade fever, an elevated white cell count, and cloudy

---

[22] *See, e.g., Marshall, supra,* 134 F.3d at 325; Summers, *supra,* 91 F.3d at 1140; *Eberhardt*, 62 F.3d at 1258-59; *Holcomb*, *supra* at 117; *Urban by and Through Urban* v. *King*, 43 F.3d 523, 525-27 (10th Cir., 1994); *Baber*, *supra,* 977 F.2d at 883; *Cleland*, *supra,* 917 F.2d at 269.

[23] Imposing such a subjective state of mind as a condition precedent for triggering the duties of subpart (b) makes sense given the structure of EMTALA. Because the identification of an emergency medical condition is based on the "appropriate medical screening examination" mandated by subpart (a), information generated by this screening will vary with "the capability of the hospital's emergency department" and with the different symptoms and history that each individual presents. Thus, it would be impossible to impose a uniform objective conception of "emergency medical condition" that would apply to all hospitals and all patients.

urine samples. J.A. 126-127. She was being given antibiotics for a suspected urinary tract infection. J.A. 126. There was no indication that any other "immediate medical attention" was warranted to prevent serious jeopardy to her health, or serious impairment to her bodily functions, or serious dysfunction to any bodily organ or part.

But the question is not whether, objectively speaking, Johnson had an emergency medical condition on July 24, 1992. The question is whether her treating physicians at Humana determined that she had an emergency medical condition. The deposition testimony and affidavits filed in the district court reveal conclusively that Johnson's physicians did not perceive that Johnson had an emergency medical condition. *See* J.A. 103, 117, 131, 133, 135. This testimony was uncontradicted.

Accordingly, summary judgment should also have been entered for respondent on the ground that the treating physicians had no actual knowledge of an emergency condition at the time of the transfer. If the treating physicians acted negligently in discharging Ms. Johnson when they did, she would have an action under state law. But on the uncontested facts presented, petitioner has no claim under EMTALA.

CONCLUSION

For the foregoing reasons, the judgment of the Sixth Circuit should be affirmed.

Respectfully submitted,

Thomas W. Merrill
Northwestern University
School of Law
357 East Chicago Avenue
Chicago, Illinois 60611
(312) 503-8074

Of Counsel

Fredric J. Entin
James A. Henderson
American Hospital
Association
One North Franklin
Chicago, Illinois 60606

Michael L. Ile
Leonard A. Nelson
American Medical
Association
515 North State Street
Chicago, Illinois 60610

Katherine O. Orrico
American Association
of Neurological Surgeons
Congress of Neurological
Surgeons
725 15th Street, N.W.
Suite 800
Washington, D.C. 20005

Robert M. Portman
Jenner & Block
601 13th Street, N.W.
Washington, D.C. 20005
Counsel for American
College of Surgeons
and American College
of Emergency Physicians

September 22, 1998